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AN APPROACH TO A THEORY OF CONVALESCENT BEHAVIOUR

WITH REFERENCE TO CARDIAC ILLNESS.

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~~Errata~~

I apologize for the fact that the early pages of this thesis have less than the standard width of margin. This mistake was rectified by my excellent typist, Mrs. P. Oldham, as soon as it was noticed.

SUMMARY

This thesis reports on a phenomenologically orientated exploratory study into the experiences of 15 men who received hospital treatment following a heart attack. They and their wives were interviewed for six months from the onset of the illness, so that their hospital treatment could be related to their convalescence.

This kind of study indicates a hiatus in the existing literature of medical sociology, both in its substantive area and in methodology. Little attention has been paid to recovery from illness, and then only to a segment rather than the whole process. This research offers a beginning, and the conclusions underline its implications and indicate areas for further study.

The illness is viewed as a crisis, during which the units of the role-set, the hospital, their wives, cardiac patients and 'others' - seek to influence the patients' experience and determine the nature of their convalescence. Ambiguity and contradictions are identified during this socialisation.

Once discharged from hospital, the patients seek to clarify their own model of the process of convalescence, being influenced by and using the models presented by the role-set. Throughout this, their perceptions are followed along two dynamic and interacting dimensions; a longitudinal dimension traces their view of movement in time, relating their perceptions of past, present and future; a lateral dimension sees them within their social context both in their relationships and in their decisions about their range of appropriate activities.

The theory of convalescence following a cardiac illness that is proposed has been generated from the empirical data, and is presented centrally to the thesis in order to emphasise its relation to the data. While this data is divided into two main time periods, i.e. the hospital and the convalescent, the themes which are identified at the beginning will be followed throughout.

1. INTRODUCTION.

The research that will be presented in this report concerns the processes which characterised the convalescence of a sample of men who had suffered a heart attack. Their progress is followed from the time of their admission to hospital, through their discharge and recovery time, for a period of six months. The majority of the thesis will analyse the empirical data, which will be set out in two separate but sequential groupings; the time in hospital leading to the time of recovery at home. On the basis of this data, a theory of convalescence will be proposed.

However, before the patients' experiences can be discussed, it is necessary first to set out the foundations of the research project both in terms of the way the study has been carried out and its relation to other bodies of theory. The first two chapters of the thesis serve these purposes. They are both of considerable length because of the conviction that only if the foundations of any research are fully explored can the value of the new material be evaluated. In the mind of the researcher, these issues are vital and it is hoped that the presentation will convey this, with no connotation that they are in any way parallel to the admonition remembered from childhood in which the bread and butter had to be eaten before any cake was allowed.

This first chapter introduces the research firstly in terms of its progress and development. Secondly, it covers at some length its methodology and methods. This section has been subdivided for the purpose of discussion into:- a) the evolution of the conceptualisation of the topic, in which the use of phenomenology is discussed as a central orientation; b) the selection of research method which relates the study to the 'grounded theory' advocated by Glaser and Strauss (1967); c) the practical constraints influencing the selection of method; d) the methods of data collection that were used; e) the characteristics of the sample. The third, and brief, section indicates the nature of the medical condition for which the sample were receiving treatment.

The summary to the chapter relates its orientation to the literature and themes which will be covered in the second chapter.

I. Progress and Development of the Research.

The origins of the research stem from a sense of dissatisfaction which was first experienced in professional practice in hospital social work and later confirmed by the inadequacy of the literature available for teaching purposes. The dissatisfaction centred around both the compartmentalisation of knowledge about the behaviour of ill people and the focus on the person who was ill to the exclusion of his social context and his 'non-ill' life. This tendency to separate out one segment of a patient's experience and view it out of its time and social contexts is not only theoretically inadequate but reflects and perhaps reinforces some of the present inadequacies in patient care.

While starting with a concern to contribute to a more comprehensive view, the exact nature of the project to be undertaken has evolved slowly. These two first chapters place the dynamics of its own development in the context of both research methodology and of the existing literature. The gaps in the literature, which will be discussed in the next chapter, are to some extent at least a reflection of the methodological orientation which underlies the research being reported; to break away from its compartmentalisation demands a different approach to research.

Following the selection of a topic which would enable this approach to be explored, an outline of the research was sufficiently formulated by the summer of 1973 to be discussed with the hospital authorities, on whose co-operation the whole project depended. The (then) Coventry Hospital Management Committee was agreeable and the proposal was presented to the Medical Research Committee in May 1973. Following this, the consultant cardiologists themselves gained the support of their colleagues in the Medical Division and the pilot study was begun in July 1973.

Contributing to the ease with which the project was accepted by the administrators and medical staff, was my own previous experience as a medical social worker. The effect of this in readily establishing a consensus of values over such things as the ethical issues in research on hospital patients and offering reassurance on my competence to implement them, meant not only that the negotiations were smooth but also that I was allowed access to patients at a very early stage of their illness - an unusual feature of many of the studies which will be referred to, but one which was vital to the design of this study.

The main fieldwork was carried out between the autumn of 1973 and the autumn of 1974.

II. The Methodology and Methods of the Research Design.

The concept and execution of the research need to be discussed in four related ways, namely, the focus of the central theme, the selection of the methods used, the practical constraints affecting the choice of methods and the actual ways in which data were collected. Running through this discussion is a developmental theme, in which the evolution of ideas and the implications of reality situations have dynamic interaction. The conceptual and practical changes resulting from this interaction will be indicated within each of the following sections.

a) The evolution of the concept

The theme of this thesis, the process of convalescence following myocardial infarction (heart attack), developed slowly from the original concept, being influenced both by practical and conceptual necessities. This 'life-history' of the concept of the research needs to be outlined briefly in order to explain the focus that is now given to it.

The original idea of the investigation was to focus onto the period of hospitalisation. The interaction between the husband, who had been absorbed into the institution of the hospital, and the dismembered family was to be examined with particular reference to reallocation of roles, patterns of communication and the extent to which the husband retained his structural position and identification with his family and his role-set. (Merton 1957)

Theories concerning the family, institutions and illness behaviour were to be related to that of crisis. Taking a structural/interactionist view, the concentration would have been on events during the period of hospitalisation with a brief period of follow-up. The pilot study, however, indicated the need for modification for two reasons. Firstly, that the time-span was inappropriate for the way the patients and their families perceived their situation, and that the focus must include a much longer period. Secondly, and related to the first, that the short period of hospitalisation meant that it was impractical to aim for more than one interview with the wife while her husband was in hospital. This again resulted in an elongation of the project and emphasised the interdependence of the period of crisis with the time of resolution. The pilot study was extended to include this modification.

The research model thus became a longitudinal study of perceptions of the crisis of illness and the factors affecting its resolution. The crisis was the independent variable, the events and perceptions surrounding it and the recovery phase the intervening variables, and the form of resolution the dependent variable. It was on this model that the data were collected.

The analysis of the data, however, showed that a further refinement was necessary. Any attempt to develop a typology of resolution involved such broad categories that they were almost meaningless. Because there was so much data on the variation in perceptions, the decision-making processes and the varied means by which each patient reached his individual resolution, any classification was superficial and risked doing violence to other significant data. For instance, if categories had been developed around the extent to which pre-illness behaviour had been reinstated, apparent similarities in behaviour would have had to be grouped together even if the reasons for them were completely different. To have allowed for categories to include perceptions, influences, decision-making and behaviour would have resulted in a unique category for each person. A far more productive form of analysis was found by examining the means or process by which each person achieved his individual end result. This, then, became the focus of the study; the intervening variables of the previous model

being the subject under study and the eventual results being allowed to remain idiosyncratic without being forced into artificial groupings.

The orientation on which this final model depends is that there is value in examining what is the shared experience of a number of people facing an objectively similar situation. Although differences in their perception of the situation will be indicated, the emphasis is not to examine what distinguished one set of perceptions from another so much as to investigate what was the common experience. The presentation is more of a 'composite cardiac patient' than a number of comparative sub-groups. Perceptions of the past, the crisis, the resolution and the future were seen by the patients and their families to be inter-related, and their view on this is accepted. This has resulted in less emphasis being placed on factual information and medical reality than on the sense that each person made of the situation that he was in and of the communications that he received. By viewing the patients as the pivot of many interacting influences, the impact and use made of these influences can be discussed.

The theoretical grounds for this orientation are drawn largely from a phenomenological approach to social events and situations. Without entering into a complete thesis on the theory underlying this, some discussion of the implications of this approach would seem to be necessary.

Sociology in relation to medical care would seem to be particularly vulnerable to the seductive appeal of positivism because of its wish to justify itself in the eyes of the scientifically orientated medical profession. To be able to demonstrate tidy and quantifiable categories may more readily gain acceptance than an examination of the world as it is experienced by real people, which may look untidy and upset preconceptions.

The case for, and the characteristics of phenomenology have been argued by Filmer Phillipson Silverman and Walsh (1972). Their argument for the need to investigate the social meanings which underly social actions offers a focus which avoids the pitfall of assuming that the same actions all have the same meaning for all actors, and that these meanings are necessarily the intentions of other actors or the presuppositions of the common wisdom in which the

researcher shares. While this search for the real world in which people interpret and act may appear to open the door to a chaotic diversity of data, the fear is apparent rather than real. For people do somehow manage to construct some coherence to their interpretations of their world and their actions have meaning. In discussing the interrelation of actions and meanings, Walsh (op.cit.p.21) writes; "What is important, therefore, is not formal rules but the procedures by which members demonstrate that activities are in accordance with a rule and thereby intelligible. Social meanings, then, and the social order which is produced by them, are the ongoing practical accomplishment of members achieved in situations of interaction."

At the same time as this approach focuses onto the real and creative experience of the actors, it also renders inappropriate the wholesale application of any body of sociological concepts; concepts which can too easily be imposed with a glibness which depends on seeing only one dimension of a 'fact'. Phillipson (op.cit.p.109) cites the example of the inadequacy of the "objective indices of class" which "often clash with individuals' conceptions of their class position". He suggests as one of the reasons that many sociologists ignore these social meanings that "practical convenience seems to be the most important criterion, for the typical 'objective' indicators of social class present fewer measurement problems than the elusive, subtle and shifting meanings attached to class". In other words, if one is seeking data which can be measured and classified tidily, the variations inherent in meanings must be ignored.

In the context of the present study, this orientation can be illustrated with reference to the potential use of two established sociological concepts; these of role and of deviance. The established use of the concept of role, with its normative and consensus-prescription connotations, has very little to offer when the focus is placed onto the efforts of individuals to carve out a role for themselves which will have meaning and coherence. In as far as it has a contribution, it is to see it as one of the factors that may be influencing the process by which an actor selects his actions; it is not something to be used

as an umbrella concept under which all data must take refuge. This is in keeping with Turner's use (1962) of the idea - "The idea of role-taking shifts emphasis away from the simple process of enacting a prescribed role to devising a performance on the basis of an imputed other role".

Deviance/normalisation concepts were, in a similar way, found to have little to offer in interpreting people's experience of the situation under study. Even Cohen's (1971) 'sceptical position' in relation to traditional criminology, which enables him to view deviance as a process, has limited applicability. For individuals who have been ill and are recovering, it is their situation which is abnormal, and their behaviour during this time is attempting to conform to the situation as they see it. To impute deviance to their behaviour as compared with their pre-illness behaviour would be to imply that their behaviour should not have changed as their circumstances changed; to impute it to the way they performed during the period of convalescence would mean that there is a recognised norm and prescription for that behaviour.

As soon as individual creativity is allowed to feature in a study, the wholesale application of abstract concepts needs to be qualified. A recognition of the part that such concepts can play is, in part, suggested by Wilson's (1970) exposition of Blumer's (1954) phrase "sensitising concepts", of which he writes "abstract ideas that when filled with particular empirical content enter into a scheme for interpreting a given concrete social phenomenon." The potential relevance which Wilson omits is that the empirical data which has explored the 'real world' as people experience it, may discredit the abstract concept by showing that it cannot be made useful in such an interpretation.

In this way, then, concepts are used selectively when they throw light on the interpretation of behaviour or when they suggest links between the present study and other formulations. The aim is to assemble and present data in such a way that it may form "constructs of the second degree, namely, constructs of constructs made by the actors on the social scene" (Schutz 1967).

b) Selection of research method

The changes in the methodology of the research must be seen as running in parallel with the evolution of the concepts that have just been outlined. Presenting them in this form is necessary both in order to give some account of apparent methodological inconsistencies and as a way of avoiding the trap of attempting to provide an artificially water-tight package which does not reflect reality. Those research reports which try to deny that there were changes in their methodology but where it and the data are incongruous would seem to be most unsatisfactory. Not only is the reader left unclear as to how the findings were achieved from the research design, but the data and the theory proposed have a tenuous relationship. The impression too easily given is that the methodology is a necessary evil to be presented in a self-justifying way rather than that in itself it was dynamic and contributed to the learning element of the research activity. The 'warts and all' presentation which characterises this present report does not profess to the tidiness these other researchers would seem to claim, but will, it is hoped, enable the reader to understand its development and therefore be in a position to evaluate the data and theory.

The first, and to some extent second, models of the research project, that have been indicated, were attempting to hold together and in tension a positivist and a phenomenological approach. It was hoped to be able to collect quantifiable data on categories of results of the crises while encouraging the respondents to give their own meaning to the situations. The purpose of modifying the style of interviewing was largely a resolution of this tension, providing opportunity to go further into the ways by which they perceived, acted and interacted; at the same time, the diary was maintained although it had become something of an anachronism. The final step in this process came with a time of reviewing the interview material; a discomfort which Phillipson (op.cit.p.96) expresses as "The increasing concern to quantify meanings and values is in itself a further step in the dehumanising process of contemporary sociology, for the more men's intentionalities are reduced to numbers and are severely distorted in the process, the more difficult it becomes to recognise

their intrinsic qualities". This late development was possible because of the kind of data that had been collected and the exploratory conception of the original design.

In its original philosophy, the research was in many ways in tune with Glaser and Strauss's concept (1967) of allowing the data to generate the theory; their contention being that if the theory is grounded in the data and 'fits' it, it will carry its own validity with it. In arguing for the presentation of confirming data, they risk the assumption that data carries with it only one possible interpretation, although they say (p.5) "One canon for judging the usefulness of a theory is how it was generated". The difficulties of starting with a 'clean slate' which Glaser and Strauss do not adequately explore, are recognised by Silverman, (1972, p.189) who writes: "Given the importance attached to comprehending the actors' view of reality, it follows that the attachment of many researchers to a priori definitions and hypotheses must also be brought into question. Such a procedure usually serves only to enable the observer to avoid coming to grips systematically with the constructs of the people he is studying. It arises because the dominant view of the research process stresses its role of testing theory and hence demands initially clearly-defined concepts. If, on the other hand, we use research to generate theory, then we are under no such restrictions. "Grounded" theories can emerge which, instead of forcing data into preconceived 'objective' reality, seek to mobilise as a research tool the categories which the participants themselves use to order their experience. If this seems to suggest primarily an exploratory role for sociological research, then so much the better." An approach such as this has implications both for the way that data is collected and for the use that is made of it. The methods by which data were collected are described and discussed in the next but one section, but some further comment is necessary here of the ways in which it has been used.

Although Glaser and Strauss (op.cit.p.6) argue for the interdependence of data and theory - "Generating a theory from data means that most hypotheses and concepts not only come from the data, but are systematically worked out in

relation to the data during the course of the research" - this still leaves the difficult question of ^{the} relationship between the discrete act which may be cited in the report and the concept which has grown from it. Because the complete data can never be presented, that which is offered must be accepted as an act of faith to be a reasonable reflection of other data which are not included. Considering the extent of researchers' investment in the presentation of their research, this assumption of integrity is surprising. In the present report, not only is extensive use made of verbatim quotations, including those which may seem 'out of harmony' with a particular point being made, but also a complete series of interviews is included as Appendix 5 so that the reader may evaluate the kind of data which are being used.

These techniques of reporting and "grounding" the theory are being discussed now and will be referred to again during the report because of the danger noted by Phillipson (1972 p.79) that "Much of what counts as exploration or description in sociology fails to provide us with the means of establishing the nature of the links between it and the actual experiences of man in particular social contexts". Later, (p.94) arguing a related point he says, "Unless we can reconstruct these processes more or less adequately on the basis of information made available by the sociologist in his interpretation, we are in a very weak position to assess its (the interpretation's) worth".

In attempting, therefore, to clarify what has already been said about the processes leading to the production of this thesis, it should be remembered that the approach has become increasingly phenomenological. Although the data as it was collected, was concerned with how the respondents perceived and made sense of their situations, it was not until a late stage when the great majority of the data were reviewed and allowed to shout their own messages that the final version of the theme emerged. To have done other than to allow this refocusing would have been to present constructs of responses and behaviour which ignored the meaning and reasons for actions and which would have been at best a replication of a common-sense facade and at worst an indignity to the real experiences which the respondents had been willing to share.

These developments in approach to methodology underly the discussion of methods, even when they are not specifically referred to.

c) Practical constraints

Before discussing the methods of data collection used in this research, it is important to note the practical constraints which played some part in determining the choice of research design. These will be considered in two groups; the first, those of a medical nature, and the second the appropriate use of interviewing techniques.

The selection of a medical diagnostic group as the population from which to draw the sample had practical advantages in terms of increasing the likelihood that the subjects would have comparable experience of such things as the length of hospitalisation. Also it was thought to mean that fewer hospital staff would need to be involved in permitting access to the patients, although this was later found not to be the case. The selection of myocardial infarction as the diagnostic group, which was initially done on theoretical grounds, was confirmed by the willing co-operation and interest of the relevant doctors. The original reasons for this choice were both that it represented a type of crisis of illness for which little or no preparation would have been made, and also it was assumed, although the assumption was proved false, that because of its critical nature individual decision-making about whether or not to seek medical care would be minimised.* Additionally, the criteria on which medical decisions to admit the patient were made were expected to have less influence than with some other diagnoses.

*Footnote: Note was being taken of Mechanic's observation (1961) that "hospital cases used for the study of some illnesses, especially the more 'routine' ones, may represent highly selected and biased cases from which generalisation may not be possible to the larger group of persons in the general population with that illness....For some illnesses, at least, appearance in medical statistics may be as much a result of patterns of illness behaviour and situational events as it is of the symptoms experienced."

The average length of hospital in-patient treatment has been shown by Logan (1964) both to vary between regions but also to be steadily shortening. The usual period for which the patients stayed in the hospital used for this research was less than had been anticipated, and the methods used therefore had to be adjusted.

This discovery related to the planning of interviews. The number of contacts with both the patient and his wife had to be realistic to the amount of time available, especially bearing in mind the degree and variety of stresses that the families were under.

Because so little reference is usually made in research reports to any awareness that the respondents are people with feelings and with rights, I consider that it is not only important to do this but also to indicate some of the effects of this value on the conduct of research. Croog, Levine and Lurie (1968) in their paper to which further reference will be made later, comment on this aspect of research. They note the need experienced by some researchers to be willing to omit some potentially relevant topics, such as sexual behaviour, in order to secure the on-going co-operation of respondents, and consider this to be appropriate. They also consider that the features of the patient's illness must be allowed to influence the timing and content of interviews - "Some issues, though important to an investigator, must simply be omitted in early interviews lest they prove upsetting to the patient". They suggest that there is value in interviews with sick people being conducted by people who have professional training in understanding and handling distress, having perhaps as a secondary advantage that medical personnel may have greater confidence in the project.

These values, which are so infrequently stated, are very much in line with the ones that I brought into the conduct of the research. My previous experience as a medical social worker in some ways made it easier to maintain them, although it also created problems which will be discussed in the next section of this chapter. The values were, however, frequently placed under tension when the research interests would demand that a topic be covered, but valuing the individual meant that it should be allowed to pass.

The pragmatic relevance of this approach was that my assurance that I would be careful not to distress patients or increase their anxiety was a condition of the Medical Research Committee's approval of the project, as was the condition that participation in the project should be entirely voluntary. It was made clear, however, that this approval would be withdrawn if I failed to abide by this. I was very willing to accept this conditional approval as the priorities it reflected were in harmony with my own. This clear statement of the basis on which trust was based enabled me to have access to patients very soon after their admission.

That participation should be voluntary, with no pressure being put on patients who were reluctant, proved to place bias into the sample, the effects of which will be discussed later. It is however an appropriate safeguard for patients, who would otherwise form a captive population, and is a necessary feature of the Medical Research Council's statement (1973) on the ethics of research.

These practical constraints need to be borne in mind when considering the methodology and design of the research.

d) Method of the investigation

There were three aspects of data collection, each of which will be described and discussed separately.

d.1) Interviews

The number of interviews with each family varied from 4 to 9, depending both on the length of the husband's stay in hospital and therefore how many interviews were held with him, and also on their continued agreement. The average number, for those who will be described as the Full Series sample, was 7.5 interviews. In calculating these figures, the Intake interview, which will be described below, has not been included, as it was usually very brief.

The Intake interview usually took place on the second or third day of the patients' stay in hospital, depending on the speed of his initial recovery and also which day I was at the hospital. Interviews were then held with him at intervals of three or four days while he was an in-patient. During this period, his wife was also interviewed at home. Following his discharge, interviews took

place at home, with husband and wife being seen together, at intervals of:- one week, five weeks and approximately twenty four weeks, from the date of his discharge. This gave an over-all duration to the research contact of about six months.

Interviews conducted in the home usually lasted an hour, and on many occasions took up to one and a half hours. The decision to interview husband and wife together was taken at the time when the study was planned around the concept of the family as a unit, coping with its structural and interactional changes. The later developments, in which the wife was viewed as a member of a role-set, meant that some opportunity to interview husband and wife separately might have been an advantage. In practice, each spouse used occasions when the other was out of the room to talk of things that they could not share between them, but these opportunities were necessarily limited. The joint interviews proved to be useful as a way of understanding their interaction and the way each responded to the views and behaviour of the other, ^{and} also of the ways that they could not communicate with each other. With half the families taking part in the study, I met at least one of the children.

Interviews with the patients while they were in hospital, were governed as far as length, and, to some extent, content were concerned by the state of the husband's health. Soon after his admission, twenty minutes was as much as most patients could manage without getting tired. The length of interviews increased as his recovery proceeded, approaching an hour by the time he was discharged. The content had to be monitored for the amount of anxiety or distress that it caused the patients, as it would have been unethical to encourage them to talk in areas that were clearly stressful if their way of coping with this stress was to defend themselves against it, by such means as ignoring it, rationalising it, etc. Over a third of the patients became distressed and weepy during early interviews when talking of subjects that were highly charged with emotion, and usually I took this as an indication that the topic should not be pursued at that time. With those patients who showed evidence of being depressed, again, the subjects discussed were monitored so as not to aggravate this. This approach is in line with Wolf's (1959) argument

that emotional stress and even the contemplation of stressful areas can increase the work load on the heart.

An additional reason for my particular care over this was that I was very aware of playing a role that was research-focused, and did not have a deliberately therapeutic content. In the early interviews, I consciously held these two roles apart, struggling to operate as an objective researcher. The tension in this was particularly great for me personally because of my previous work experience. It was only after I had proved to myself that I could work in this way, that I was in a position to be able to evaluate its effectiveness for this kind of research. I then became increasingly convinced that the purpose of the research would be better served if I allowed myself to play a number of roles more flexibly, so that interviews could have a supportive and therapeutic element as well as the central investigatory purpose. The reasons for this were that it not only seemed ethically right to put into words that I cared about the patients as individuals, could accept their attitudes without criticism and was prepared to feel their situation as they felt it, but also that this was a way of obtaining certain kinds of sensitive material that might otherwise have been withheld. In other words it was a way of getting behind the presentation of a facade to their real experience which could only be achieved and justified by a greater degree of involvement on my part. This necessitated a very acute kind of listening which could differentiate their real from their facade presentations, which relied as much on 'hearing' their non-verbal as their verbal communications.

This less inquisitorial, more supportive form of interviewing was adopted gradually and characterises most of the interviews that were undertaken. With its greater emphasis on listening, it was less necessary to ask a lot of direct questions of a specific nature. This gave an opportunity to follow the themes that the respondents were concerned about, with my initiating material only when a topic had 'died' on us or the conversation had become completely irrelevant.

Three further aspects of this need to be noted. Firstly, that the formation of a strong relationship with the respondents, in which they knew that I was

interested in them as people and not as mere research data and in which I would respond to their feelings that they conveyed, was essential not only as a way of enlisting their real co-operation with the project, but also to bridge the intervals between interviews during the extended follow-up period. For those families who found the final interview largely irrelevant to their perception of their recovery from the illness, the strength of the relationship seemed to be the main factor in securing their participation.

Secondly, by allowing a therapeutic element to the relationship, the respondents' need for a helping person could more readily be identified. None had been referred to a social worker, and none had major practical problems that they could not resolve themselves. Yet many families had a degree of anxiety and concern which meant that they found talking to a third person was helpful to them. Many put this into words during or at the end of my contact with them. Using Hollis' (1966) classification, the forms of help that they drew out from the research interviews were mainly Sustainment and Reflective Discussion of the Person - Situation Configuration. In the current pressure on social work resources, these undramatic, intangible problems are receiving very low priority, and it is therefore noted in passing that casework help could have been used effectively by at least some families.

Thirdly, the extent of the structuring of interviews was modified. It had never been intended to structure interviews tightly, although a loose structure had been proposed which would have followed the developmental stage of the illness. By placing greater emphasis on following what the respondents wanted to talk about, however, even this became inappropriate, and I came to view the semi-structured framework as relating to the complete series of interviews with a family, rather than planning each individual interview in advance. This fluid approach proved to have great advantages in allowing the constant flux of expectations and perceptions to be identified. To illustrate this point with an incident which will be discussed in more detail in the main analysis, a patient talked spontaneously on two different occasions about a friend of his who had had a heart attack; the differences between what he said on the two interviews reflected his changed perception of his own situation.

This kind of material was accessible because spontaneous conversation was encouraged. The fact that this method of interviewing does not allow for the extensive collection of factual information which could be tabulated and correlated is not considered a disadvantage in an exploratory study of this size in which comparisons between sub-samples would be inappropriate.

4.2) DIARY

The use of a diary in conjunction with other research methods has been a feature of recent studies such as that of Robinson's (1971) The Process of Becoming Ill. Its validity as a research tool has been assessed by Rogmann and Haggerty (1972) who argue it is a way of gaining access to material which is undramatic and quickly fades from memory and also that the information that is gained can be placed within the fluctuations of the social setting, because the date of it can be identified. While these studies were both investigating pre-illness behaviour, it seemed reasonable to attempt to use the method with respondents who had been defined as being in a state of acute illness.

The diary was designed in the light of the initial proposal of the theme of the research, and was intended to monitor changes in the patients' contact with and interest in the 'outside world' during their hospitalization. By asking about such things as the main areas of conversation with visitors, the possibility of movement from preoccupation with illness to greater interest in the home and normal activities could be charted. While most studies of people within institutions make some reference to visitors from the outside - for instance Cohen and Taylor (1972) and P. Morris (1965) for penal institutions, and Coser (1962) and Barnes (1961) in the Hospital setting - these have not attempted to examine the content of the interaction that takes place during visiting periods. Coser (op.cit.) assumes a totality of the hospital, in Goffman's (1964) sense, which makes these contacts very unreal. She writes (p.4) "Like a ship or a fortress, just so does the hospital separate a man or woman from family life and erect around him a new social framework within which he learns to be a patient. While the patient lies in his bed in the ward, the outside world recedes from view....even his relatives..may come to seem 'strangers'.

divorced from the main problem that faces him now: the problem of cure. Family and friends belong to past and future and wear an air of unreality". And again later (p.41) "As long as the patient is at home, even if he is bedridden, he has some control over his surroundings. He is kept posted by friends and relatives on the happenings of the day, and he tends to maintain some control over the family's daily schedule...As soon as he enters the hospital, however, he loses even this limited control over himself and over the people with who he is accustomed to interact daily. Physical removal from his normal environment also means complete dissociation from his normal social role."

The first model of the research intended to examine assumptions such as this by a daily charting, while it was fresh in the mind, of the content of the interaction. While this has to some extent been done by observation rather than diary by Duff and Hollingshead (1968), their classification of topics seemed inappropriate, and they did not investigate the possibility of changes occurring during the time-span of the admission.

This area of data collection became less relevant to the theme of the research as it developed over time, but the method was maintained, and produced valuable data, even though it is little used in this report.

The form of the diary was slightly modified after the pilot study, being both simplified and demanding less subjective comment. A specimen of the revised diary is included as Appendix I. The patients were given the diary early during their time in hospital, usually as the first main interview to follow the brief Intake Interview. They then completed a page for each day, the diary being collected from them normally at the first home visit after their discharge. The number of days of the diary that each patient completed related directly with the length of his stay in hospital. The fewest number was four days, and the greatest number was thirteen; the average being nine days.

The diary was designed to leave enough space for topics to be developed if a patient wished to do so, without creating the impression of formidable blanks which might have been discouraging. Only one patient expressed reluctance to do it, but he continued even when given 'permission' to abandon it. Most patients

found it reasonably enjoyable, once they had been reassured that their handwriting and spelling were not important. There was considerable variation between patients in the extent to which they completed more than the factual information - some added nothing, while one used the diary as a means of continuing the dialogue with the interviewer to bridge the gaps between interviews.

Having embarked on the use of the diary as part of the research design with clear reasons for doing so, it was difficult to decide whether to continue it after the central theme had been re-focused. I decided to do so both because the exploratory design meant that all data had some potential relevance, and also because the material had an intrinsic interest which meant that it would be worth completing even if eventually it was analysed separately and for different purposes.

d.3) Medical questionnaire

The reason for including this within the design was to redress the imbalance which can easily occur in studies of patients' behaviour between the sociological and the medical features of the topic. The clinical aspects of even one diagnostic category cannot be assumed to be identical, but these reality differences are too frequently overlooked. In its rejection of the sufficiency of clinical explanations, sociology can go too far in discounting even major variables within the medical condition itself. If some clear categories of responses to the illness had emerged from this study, they would have been of limited value as explanations of behaviour unless it had been possible to examine whether or not they correlated with major clinical features. While the study has not produced any such clear patterns of responses, the data from the questionnaires was still of value in indicating that a wide range of possible clinical features were represented within the sample, thus increasing the reliability of the findings.

In its form, the questionnaire was extremely brief and simple, both because a large amount of technical information would have been of little value and also to make a minimum demand on the time of the consultant in charge of the Coronary Care Unit.

It asked only for a classification of the myocardial infarction into Severe/Moderate/Mild, and for any medical factors which might complicate recovery. As it was completed by the doctor within the first week of the patient's stay in hospital, during which time the medical record was readily available to him, it was possible to ask only for information available during the early stages of treatment.

The form was completed for every patient in the sample. A copy of it is included as Appendix 2.

e) Sample

The criteria for including men within the sample were:-

1. that they should be being treated for their first myocardial infarction, having had no history of medical care for angina. The purpose of this was to control ^{for} the behaviour during the present illness being influenced by a previous similar one, or a medical regime to prevent serious illness having been already established.
2. that they should be married, and living within Coventry or its neighbourhood, so that home-visiting was practicable.
3. that they should be of working age and employed.
4. that they should be of British or Irish origin, both to ensure that language did not interfere with communication, and to limit the range of cultural factors, such as attitudes to illness and family patterns, to those found in Western society.
5. that they were willing to take part in the research.

Two men did not meet criteria 3; Mr. Archer was already retired, and Mr. Berry had only worked occasionally since injuring his back, but was seeking regular work. As these two patients formed the pilot study and were the only ones available at the time, they were interviewed as the purpose of that study was to test the research design. It was only later, when it had been found that the material from the pilot study was comparable with the main study in almost every way, that it was decided to analyse the data on Mr. Archer and Mr. Berry in conjunction with that on the other patients. Their discrepancy over criteria 3

did not prove to be disadvantageous, as the shape of the study modified.

The original intention had been to have a sample of 20 patients, a number selected somewhat arbitrarily to be both adequate for an exploratory study, and yet manageable in the time available, as I had a limited number of hours available for interviewing each week. However, this became impossible to achieve. Within the seven months, November 1973 to May 1974, that were available for in-take into the sample, which was necessarily demarcated to allow time for the follow-up interviews, there were fewer patients than usual being admitted to the Coronary Care Unit. Neither the medical nor the nursing staff could account for this, although jokingly they put it down to the three-day-week which occurred during this period. There were twenty-one occasions when I went to the hospital to inquire about their new admissions that the C.C.U. had no patients suitable for my sample.

e.1) Intake to the sample

Having been given permission by the Medical Division to interview any patient who agreed willingly to my request, decisions about which patients to include were made by myself in discussion with the senior nursing staff on the ward. The senior nurse on duty would tell me which patients in the C.C.U. were being treated for a first myocardial infarction. I then read the patient(s)' medical notes to check that they met the criteria for the sample. On the few occasions that there was more than one suitable patient at a time, I would select the one with children living at home as this provided additional material for the investigation. As this usually meant the patient was younger, it also resulted in ensuring that the younger age group were represented in the sample. Having decided which patient I would invite to take part, the nurse would then tell me whether he was well enough to be interviewed then or whether I should return in one or two days' time.

When the first approach was made to the patient, after introducing myself, I explained that I was doing research into "the ways in which having heart trouble suddenly affects people and their families.....that this isn't the same for all families and I would be interested to know about your experience".

I made it clear that there was no pressure on them and that refusal did not affect their medical treatment. I also said that I was not in a position to be able to offer any help if they did meet any problems, but that they would be contributing to a greater understanding of the effects of illness. Many responded to this by saying that they would like to help the staff to understand more, and thereby be of help to patients of the future. On those occasions when the wife was visiting when I first approached the patient, her agreement could be obtained at the same time, and a home visit arranged. When I did not meet the wife at the first contact, I obtained the patient's permission to write to her. A copy of this letter forms Appendix 3.

Having obtained the patient's agreement, notification that I was interviewing the patient was sent both to the consultant under whom the patient had been admitted and also to the consultant in charge of the Coronary Care Unit. The latter was also requested to complete the medical questionnaire. This letter is reproduced as Appendix 4.

e.2) The patients

Of the hospital patients who were invited to take part in the research, it is necessary to distinguish between:-

- a) the refusers. Those who chose not to be included in the research.
- b) the withdrawers. Those who agreed to take part but who did not continue for the full series of interviews, for any of a number of reasons.
- c) the full series. Those with whom contact was maintained for the full period.

Basic social and demographical information will be given for each of these groups. Some additional comment will be made of the refusers, who will then not be referred to again in the study. Although information on the withdrawers is less complete than on the full series respondents, these two groups will be considered together when analysing the data.

The refusers

Mr. W. aged 52. Married. Adult son. Skilled occupation. Mr. W. was very suspicious about the research, thinking that there was some ulterior purpose, and that "someone was trying to make some money". He said he had heard about a survey in

his neighbourhood into "people with arthritis" (probably the Social Services' Department survey which was a requirement of the Chronically Sick and Disabled Persons Act 1970), and he had told this investigator to "get lost". He clearly wished to say the same thing to me.

Mr.X. aged 55. Married. No children. Semi-skilled, self-employed occupation. I introduced the research to him, saying that I was "talking to people who have had heart trouble", to which he replied "There must be some mistake - I haven't got heart trouble. I've got bronchitis. The doctor told me this morning. I can't help you". On checking with the Ward Sister, I confirmed that he had been told that he had had a heart attack. On re-viewing his medical notes, I found that the history of his symptoms that he had given the doctor was extremely confused, and would indicate either that he was excessively anxious or of very low intelligence. For whatever reason, he was denying that he had had a heart attack.

Mr.Y. aged 40. Married. No children. Skilled occupation. Mr. and Mrs. Y were seen together when I asked them to take part in the research. He seemed reluctant and said he would have nothing to say to me. His wife then spoke for him, with him indicating his agreement "If he gets over this, please God, he'll just want to forget it's ever happened - not go on talking about it".

Mr.Z. aged 53. Married. Children - not known. Skilled occupation. He talked very freely after my explanation of the research, going into considerable detail about the onset of his illness. He then said "There's no more to say - I'm getting better and will be back to normal soon.....I want to forget about it".

Mr.W.'s response was a very individual one, indicating a high degree of suspiciousness which may be viewed as an aspect of his personality, under the stress surrounding his illness. His connection of the present research with the survey in his neighbourhood may at least in part have been occasioned by the disability of the researcher, though there is no definite evidence for this. The extent to which this disability affected any other respondents is extremely hard to assess; although most asked about it when chatting informally, the general impression gained was that it had no effects on the data collected,

although it is recognised that it may have contributed to Mr. W's refusal.

Mr.X, Mr.Y and Mr.Z present a very different type of response from Mr.W. Although in different forms, they were each operating some degree of denial, either of the existence or of the implications of the heart attack. In view of the undertakings that had been given to the hospital authorities that participation in the research should be entirely voluntary, no pressure could be put onto these patients to persuade them to change their minds. Nor did it seem to be ethical to distort what the research was about in order to gain their agreement, although in practical terms, this could have been done. In addition to this, the very fact of encouraging people to talk, and therefore think about their situation when they did not want to, would almost certainly have resulted in major modifications to the data that would have been collected, possibly causing them an unreasonable degree of anxiety. While it is recognised that some degree of modification took place in those families who wanted to talk, and that this could form a subject for research in its own right, consciously to induce change for the sake of research would seem to be unjustifiable.

This suggests a very real methodological problem for research connected with medical care. The potential population which could be sampled were 'captive', in that they were housed in the hospital for the sake of obtaining medical treatment. While it was an advantage that the research was totally independent of the medical treatment, this also meant that patients were able to refuse to be part of it without placing their treatment in jeopardy. However, refusal was not random. It correlated highly with a response that was characterised with some form of denial either of the illness itself, or of its implications. In contrast, the Full Series respondents did not show marked forms of denial, while the withdrawers had a mixed set of responses, some of which began to demonstrate denial as time went by. This must therefore suggest that one segment of the range of possible responses was self-excluded from the research, and that this was inevitable because the research was independent of treatment. The implications of this for the data that is analysed and the conclusions that will be drawn from it must therefore be noted and borne in mind as a qualification to the theory that will be proposed.

The Withdrawers

There were four respondents who withdrew during the period of the research.

They were:-

| <u>Name</u> | <u>Age</u> | <u>Occupation</u> | <u>Severity of heart attack</u> | <u>No. of days in hospital</u> |
|-------------|------------|------------------------|---------------------------------|--------------------------------|
| Mr. Berry | 48 | Light labouring | Moderate | 15 |
| Mr. Cook | 51 | Storeman | Mild | 14 |
| Mr. Irwin | 60 | Unskilled factory work | Severe | 19 |
| Mr. Oliver | 47 | Lorry loader | Moderate | 9 |

These can be subdivided into those who withdrew before the final interview - Mr. Berry and Mr. Irwin - and those who refused all home-visits after their discharge from hospital - Mr. Cook and Mr. Oliver. Both Mr. Berry and Mr. Irwin showed a wish to minimise the effects of their heart attacks, and indicated that they thought the final interview of the series was so irrelevant that they did not wish to take part in it. In addition to these shared responses, Mr. Berry had marital difficulties and resisted his wife's attempts to make his illness an agent for changing their relationship, giving him a vested interest maintaining the status-quo. Mr. Irwin had a moderately severe degree of depression both during his time in hospital and after his discharge, and could not believe that what he had to say was of any interest to the research. From the short but intensive contact with Mr. Cook and Mr. Oliver while they were in hospital, it is reasonable to deduce that there were relationship difficulties between them and their wives which they did not want to be openly exposed. I am also aware of having mishandled a situation with the Oliver family - when his wife failed to keep to the third appointment that had been made to interview her, my anger showed itself quite clearly, and although it was later possible to have a satisfactory interview with her, I think that he was so aware of my feelings that the relationship was damaged. The need for a strong relationship to sustain the interviews over the full time-span had already been discussed and on this occasion it was my spontaneous response that damaged it.

The Full Series Respondents

The eleven respondents in this group were:-

| <u>Name</u> | <u>Age</u> | <u>Occupation</u> | <u>Hospital Doctor</u> | <u>Severity of Heart attack</u> | <u>No. of days in hospital</u> | <u>No. of weeks off work</u> |
|-------------|------------|-------------------------|----------------------------|-------------------------------------|------------------------------------|----------------------------------|
| Mr. Archer | 71 | Retired toolmaker | A | Severe | 18 | N/A |
| Mr. Dodds | 54 | Management | B | Mild | 10 | 17 |
| Mr. Easton | 46 | Management | C | Severe | 15 | 17 |
| Mr. Fraser | 51 | Designer | D | Moderate | 9 | 8 |
| Mr. Gould | 43 | Skilled factory | E | Moderate | 16 | 11 |
| Mr. Hewitt | 56 | Unskilled factory | F | Mild | 8 | 12 |
| Mr. Jessop | 61 | Skilled factory | A | Moderate | 13 | 22 |
| Mr. Keoghan | 48 | Skilled factory | F | Moderate | 15 | 19 |
| Mr. Langton | 59 | Director | C | Moderate | 13 | 14 |
| Mr. Mears | 54 | Semi-skilled factory | G | Moderate | 14 | 14 |
| Mr. Neale | 63 | Storeman | D | Mild | 16 | 8 |

This information is set out, not only to serve as a point of reference when the experience of individual patients is discussed later, but also to demonstrate the lack of correlation between the various categories of information. The severity of the illness related neither to the length of hospitalisation, nor to the length of time off work. Nor is age a determining factor in these. The consultants are differentiated in order to indicate the impossibility in a sample of this size to infer decisions about the length of treatment from the policy of any particular doctor.

To recapitulate the point made earlier, the withdrawers and the Full Series respondents are together taken as the sample for the purpose of analysing the data.

f) Summary of methodology and methods

This discussion has highlighted the developmental aspects of the process of research and related these to the task in hand. The division into five sub-sections was necessary in order to consider each aspect of and these have moved progressively from the general to the particular. The section is, however, essentially a whole in which the formulation of the design evolved as changes and developments were allowed to carry through their effect.

The outline of the sample has two major spheres of importance. Firstly, it is a preliminary indication of the implications of the methods being employed, in that it shows how the project was presented to potential respondents. Secondly, it introduces the patients whose experiences will be discussed in this thesis, and in this way looks forward to the later chapters. To summarise the information on the sample; nineteen patients were invited to take part: of these, four exercised their right not to be respondents and their views were described under the heading of 'the refusers'; four began taking part in the series of interviews, but withdrew before the end; eleven continued throughout the full time-span of six months. The only significant difference between these sub-groups of the sample that can be identified was in the form in which they expressed denial of the illness. The refusers, in three cases out of four, were denying either the existence or the implications of cardiac illness; the withdrawers were sometimes beginning to use it as time passed; the full-series respondents did not demonstrate the same tendency to deny. The implications of this self-selecting-out in introducing bias into the sample have been recognised. The withdrawers and the full-series respondents, whose experiences are analysed together, have been shown to represent a wide spread of age, occupation and severity of their illness.

III. The Medical Condition of Myocardial Infarction.

Myocardial infarction, coronary thrombosis and heart attack are generally taken to be interchangeable names, with the latter two being better known and in general usage. While to all intents and purposes they mean the same thing, clinically, the thrombosis or clot which blocks off the coronary artery thus preventing blood reaching the heart is the cause of the infarction (death of an area of tissue) of the myocardium (the heart muscle). Houston Joiner and Troncoe (1968 p.154) describe it as; "When a large coronary artery is obstructed by thrombosis the patient may suddenly fall down dead....More often, however, the patient survives, and over the next few weeks the dead heart muscle is absorbed and replaced by a fibrous scar. This scar may be firm and strong, but occasionally, particularly if the infarct has been a large one, the scar may become stretched and produce an aneurysm (a dilated and weak patch) of the heart wall.

The functional ability of the heart may be near normal after an infarct, but sometimes after a large infarct, the loss of infarcted muscle so encroaches on the reserve power of the heart that congestive failure occurs, or the patient may be left with crippling angina^{of} effort."

After discussing the clinical features and medication that may be required, Houston Joiner and Trounce say "The patient must,be kept at complete rest in bed for about four weeks" (their italics). Considering that the third edition of their text was revised in 1970, such a definite statement about the length of treatment in bed is indicative of the variety of medical opinion about post-infarction care. The hospital where the research was done seldom kept patients on complete bed rest for more than a week or ten days, and frequently for much less. A Canadian study by doctors (Wigle et al. 1971) on return to work following myocardial infarction suggested "Early ambulation following infarction and encouragement to progressively increase the level of physical activity reduce psychosomatic complaints". The continuing debate about optimal treatment is reflected by a study by Hayes et al. (1974) who found no difference in later symptoms on recurrence of illness between patients kept on bed rest for two or nine days.

Of subsequent management, the medical text continues (p.157) "When the period of rest has finished the patient is gradually allowed up, but should not return to work for at least three months after the acute attack. If possible the patient should return to his normal employment. If, however, his job is exceptionally heavy or if he is severely crippled by cardiac failure or angina of effort, then some change will be necessary. Overweight patients should be dieted until they reach normal levels.....Otherwise the patient should lead a normal life, but avoid excesses of all kinds."

When differing kinds and degrees of physiological permanent damage are combined with the possibility of psychosomatic complaints, to use Wigle et al. (op.cit.) term for it, and variable social and environmental conditions, the extreme complexity of predicting the result of any individual's myocardial infarction can be seen.

The incidence of myocardial infarction has proved to be almost impossible to establish as official statistics reflect only deaths or hospital admissions. The difficulty is reflected in Kinlen's study (1973) of the Oxford region, and he indicates that considerable regional differences exist. He investigated all hospital and General Practitioner patients who might have myocardial infarction and also all notified deaths. He estimated that in Oxford per 1000 men aged under 70, the incidence of myocardial infarction was 4.5. Of these, "In about 17%....there was a previous history of proven myocardial infarction."

A Swedish study, conducted by Wilhelmsson et al. (1974), which reported on the results of a new drug treatment, used as a control group post-myocardial infarction patients who received a placebo. In this control group, during a period of two years, the incidence of further infarctions was about 10% and of death was about 8%. Ahlmark et al. (1974), writing about the same drug treatment gave as figures for their control group, a recurrence rate of 16% and a death rate of 13%, indicating that the majority of both of these occurred in the first year.

The relevance of such studies to a sociological inquiry is only to indicate the reality behind the fear experienced by the sample patients that their heart attack might recur. No significance can be claimed, in a sample of this size, for the fact that none of these patients had a recurrence or died within the six months period of the study.

IV. SUMMARY

This chapter has built the first layer of the foundations of the research report, without which the later superstructure of the empirical data would be insubstantial. By opening to view the developments in architectural design and engineering technique, to pursue the building metaphor, the process of research has been recognised to be dynamic. The exposition of the orientation on which the thesis is based has been lengthy as it is essential to an understanding of the theory that will be proposed later and the use that will be made of the data. This phenomenological approach is concerned with seeking to understand the patients' experiences and the meanings they gave to their

situations rather than with the collection of classifiable facts'.

This same approach underlies the next chapter, which will discuss the relation of this research to the existing literature. Although the relevant literature is at first sight extensive, an orientation which focuses on the patients' experiences demonstrates its limitations. In this way, the two chapters have an essential continuity, and together provide a firm foundation to the theory which will be built.

2. GENERAL THEMES, AND RELATION TO EXISTING THEORY.

A wide-ranging, exploratory study of this kind clearly has both conceptual and substantive links with a great many areas of theory which have already been formulated. A partial listing of these could include:- the full range of medical sociology with illness behaviour in particular and especial focus on cardiac conditions, rehabilitation, institutions and hospitals, the family, socialisation and subculture, and crises of every kind. A comprehensive review of all these literatures would not only demand a series of theses devoted specifically to that purpose but would in any case be inappropriate to the task in hand. The very fact that each of these literatures forms a more or less self-contained body of theory, which, if based on research, takes a positivist approach, is in itself a limitation to their direct applicability, as the present study cuts across these boundaries and is phenomenologically orientated. The aim of this chapter is to discuss the relation of the research to selected aspects of these theories, with the full realisation that other areas of the topics are not being included. In doing this, the proposed theory of convalescent behaviour following cardiac illness will be seen both in the context of these groups of knowledge and, on some occasions, as challenging their adequacy.

The chapter begins with a discussion of one section of the extensive literature of medical sociology, that of patient career, and will indicate a substantive gap which this thesis contributes towards filling. The dearth of studies of rehabilitation is then referred to and the points of alignment are identified between needed research into rehabilitation and the present research. This leads to a discussion of the way that institutions have been studied and highlights the limitations of a traditional approach to which a different kind of contribution is now being offered. Brief reference is then made to theories of the family and of crisis. The chapter concludes with a discussion of the concept of process as it is found in the literature and as it is being used in this thesis, which is then related to other studies of myocardial infarction. In doing this, the central importance of the methodology indicated in the previous chapter is again emphasised.

I. An Aspect of the Literature of Medical Sociology.

Writing in 1963, Freeman, Levine and Reeder considered that the contribution of sociology to medical practice had been concentrated more on studies of the setting of medical care than on the patient who was being treated. While the orientation of sociology as contributing to medical care could justifiably be called into question, the main point of relevance to the present discussion, is to highlight the comparative recency of studies which have focused onto the patient, and especially the biographical career of the person experiencing an episode of illness. Biographical career is being used in the present context to imply two orientations, firstly, that the sequence of events which the individual experiences as a result of being ill have a dynamic life-history of their own; but also, secondly that the illness episode is only a part, albeit often a major part for a short time, of an individual's complete biography both as a unique person and as a member of a family.

This new emphasis has had two general directions. On one hand, it has tried to relate aspects of illness to general theories such as those of role (Gordon 1966) and crisis (Glasser and Glasser 1970). Most of the work in this area has been concentrated on individuals to the neglect of the family; a point which Vincent (1970) makes saying "minimum attention has been given to what the illness does to....his marital health". The second main direction has been to attempt to refine the roles and related behaviours that characterise the stages of developing illness and the tenure of the sick role. Robinson (1971) has explored the decision making processes which determine how symptoms are perceived and defined. A comprehensive review of the literature on the "patients' paths to the doctor" by Stead et al. (1963) indicates the diversity of factors which influence a decision to seek medical aid, as distinguished in a multiplicity of studies. Studies on the period of acknowledged illness have, very largely, been concerned with re-examination and refinement of Parson's (1951) model of the sick role. In addition to cross-cultural studies, such as Butler (1970) and Sharval (1972), it has been examined in relation to deviance theory by Bagley (1971) and in relation to different types of illness by Twaddle (1969) and Kassebaum and Baumann, (1965).

The most comprehensive resume of all this research is that undertaken by Kael and Cobb (1966) who offer a frame-work within which separate pieces of research may be related to each other. Their diagrammatic presentation indicates the range of the material they were covering:-

| Behaviour | Health | | Illness | | Sick role | |
|------------------|--------------------|----------------------|---------------------|------------------------------|--------------------|-------------------|
| Identity | Healthy | | Feel sick | | Am sick | |
| Role performance | Usual social roles | | Diminished function | Preparing to enter sick role | Being in sick role | Leaving sick role |
| Health | Health | Asymptomatic disease | Symptoms | Diagnosis | Treatment | Outcome |

Diagram 1.

Kael and Cobb's Figure: The continuum from health to disease, related to behaviour, identity and role performance.

This diagram is reproduced both because it represents the current areas of interest and study, and also because the omissions from it highlight the current hiatus in knowledge. The 'behaviour' and 'identity' rows are portrayed as completing their cycle at the respective points of 'sick role' and 'am sick', with the presumed assumption that 'health' and 'healthy' would follow automatically while the lower two rows are still in the stage of resolution. In the accompanying text, they cite fewer studies of 'convalescence' than of other topics, and those referred to concern mainly the length of convalescence following surgery. Although this might be considered to be a more predictable and standardised time-period than the very variable expectation with regard to myocardial infarction, even the study by Moss, Schwagman and Dohan (1957) which they review "revealed considerable disagreement (between doctors) about the recommended intervals for return to light or heavy work after different kinds of surgery. The authors of the study believe that this indicates a lack of adequate medical criteria for determining duration of convalescence". After comment on a few other studies, they conclude the section - "recovery is defined as leaving the sick role to resume normal social obligations". The paucity of studies available to Kael et al. would seem to be an accurate reflection of the lack of interest shown by researchers in the later stages of patients' illness biography.

Although this rather sweeping statement will later be qualified by a discussion of the kind of studies that have been done, it is important first to examine a conceptual difficulty which underlies the assessment of the relevance of these studies. This concerns the type of classification of illness under which myocardial infarction should be considered. If this classification is based on the social implications of illness, as distinct from a clinical classification, considerable ambiguity is found. In an analysis such as Watson's (1972) which he calls 'illness graded according to social severity', he himself has no doubts about the correct allocation of myocardial infarction. A summarised version of his scheme (p.23-4) would read like this:-

"Grade 1. Acute, simple, non-recurring, trivial or serious, with complete recovery and causing no alteration in the total life pattern.

Grade 2a. Acute, simple, non-recurring...from which the patient makes a complete recovery but which nevertheless affects some aspect of living.

Grade 2b. Recovery is only partial and the patient is left with a complication of his illness which may be major or minor and which has some adverse affect on his future.

Grade 3. This is an acute, serious illness with the possibility of recurrence, which the patient survives but which leaves him with permanent disabilities of a physical or statistical nature. Examples are myocardial infarction.....(etc).

Grade 4a. This is chronic, non-fatal illness, requiring continuous management, but having no effect on the total life situation.

Grade 4b. This is also a chronic non-fatal illness requiring continuous management, but in which the life situation is affected.

Grade 5. This is chronic potentially fatal illness which requires continuous management or supervision and which impinges on the total life situation.

Grade 6. This is terminal illness, whether of recent or remote onset."

While Watson has no apparent hesitation in his designation of myocardial infarction to Grade 3, this cannot be assumed to be true for all doctors, especially if their implied views are taken to represent their intended statements;

these are, after all, what the patients hear, perceive and respond to.

Different aspects of doctors' reported statements could reflect a designation of myocardial infarction to any of the first five categories.

While the following chapters will explore the empirical significance of this confusion, the relevance of it to the present discussion is that it highlights the difficulty of knowing what range of studies to draw on for appropriate comparisons: should these be studies which, often without specifying it, take a model of acute and resolving illness, such as most of the work done on illness behaviour by people such as Mechanic, with or without Velkoff (1960, 1961, 1963), or should the parallels be sought among studies of chronically disabling conditions, of which Davis's (1963) remains the most outstanding example. The situation is still further complicated by the fact that studies which span the full range of types of illness that are treated within a hospital pay scant attention to post-hospital developments. An example of this is Duff and Hollingshead's (1968) extensive empirical study of hospital patients in which they write-up almost nothing of their findings from follow-up home visits; similarly King's (1962) theoretical analysis of patients' treatment for illness stops short while his patients are still receiving hospital care.

Issues which are essentially similar to these were addressed by Blaxter in her recent study in Aberdeen of patients discharged from hospital. In her paper "Processes of Recovery and Rehabilitation", she examines the ways that individuals come to define their own situations in interaction with the definitions imposed on them by medical and administrative systems. Investigating a mixed-diagnosis group of patients, she proposes a very open definition of terms - " 'Disability' like 'sickness' is a relative term and cannot be precisely defined. As there is a continuum between sickness and health, so most people are physically disabled to some degree, and the place on the continuum that an individual finds similarly depends on factors of perception, identification, cultural concepts of normality, social and family environment, and individual factors of personality, as well as on clinical 'facts'. Rehabilitation, defined in a commonsense way, as the best possible medical, social and vocational readjustment of the patient within the limits of his physical impairment, is similarly relative. A given impairment may

or may not result in functional disablement, and if it does, the individual may or may not need formal rehabilitation help: in both cases the variables are numerous and complex". In examining the development of definitions and redefinition she underlines the potential for disharmony between the definers, and the confusion that can result.

In the present study, a similarly 'open' approach will be taken in categorising myocardial infarction, that is, that it may be seen to feature in any of the first five of Watson's (op.cit.) categories, depending on the perception of it formed by any individual in his interaction with other definers. This view makes possible the eclectic use of studies which are either implicitly or explicitly concerned with particular typologies of illness in order to extrapolate from them concepts which can be used to develop a theory about convalescence, as the developing stage of a process.

II. The Need for Research into Rehabilitation.

The literature on rehabilitation is limited both quantitatively and qualitatively, often reverting to either lamenting the inadequacy of services or setting out areas that need research. Such as it is, it can be divided into the general literature and the specialised cardiac literature, although both tend to confuse rehabilitation in its own right with vocational resettlement.

The shared ground between the many definitions of rehabilitation concerns ways of facilitating the best possible medical, social and economic readjustment of a patient within the limits set by his medical condition. One of the major studies of the topic, by Safilios-Rothschild (1970), calls it "the institution that makes up for the deficiencies in medical care in terms of its lack of comprehensiveness in services rendered and its limited responsibility to the patient. Utilising a wide range of practitioners, rehabilitation has as a goal the maximisation of ability in all areas of those who at the termination of medical care have residual disabilities that interfere with or inhibit their 'normal' functioning." Both this work, and the other major theoretical source, a symposium edited by Sussman (1966), are conceiving rehabilitation only within the setting of an institution specifically designed for that purpose. Although this

means that some care must be taken in extrapolating from such sources into the realm of informal and uninstitutionalised convalescence, some valuable leads can be found.

Sachman, (in Sussman op.cit.) for instance, proposes two models of needed research; firstly, one which would view rehabilitation as an intervening variable modifying the relationship between a disability and its consequences; secondly, as an evaluative model testing the effectiveness of rehabilitation to affect the consequences of disability. In discussing the first of these, he says that it would lead to "analysing the process by which a disability becomes a handicap", which must include a consideration of environmental variables. In this view "Rehabilitation may become a form of primary prevention in which the emphasis is placed on preventing the reoccurrence of the health condition through changes in the host, agent or environmental factors". In considering the question of modifying causative factors and reducing negative consequences, he points to the need to study the natural rehabilitative process, so as to find those factors "outside of formal rehabilitation programmes which affect among whom, how, when and why different reactions to disability take place". (p.55-60)

The difficulty of achieving Sachman's second sphere of research, that of evaluation, has been set out by Hefferin and Katz (1971) who reviewed existing research on this. They concluded "Evaluative study that helps to combine the worlds of research and practice in rehabilitation requires the development of precise tools to assess the patient's performance in the face of various physical, social, and psychological demands of treatment and nontreatment environments..... there is as yet no standard technique for evaluation of treatment outcomes in rehabilitation."

Magi (in Sussman op.cit.) goes further in connecting the preventive aspect of rehabilitation with social processes. He uses the term 'disability' to mean "a pattern of behaviour that evolves in situations of long term or continued impairments that are associated with functional limitations." Using this definition of the term, he argues (p.112) for research - "Outside the psycho-analytic framework, we know little about the behavioural processes and phases of disability and the sociological factors involved....what is suggested is the need for longitudinal

studies, beginning at the onset of impairments. The process of rehabilitation is largely a reversal or prevention of the process of disability. An understanding of the course of the latter process should provide a better basis for experimentation with timing and techniques of intervention which would enhance the use of rehabilitation as a measure for the prevention rather than the remedy of disability".

From a medical perspective, work on rehabilitation has tended to be a 'poor relation', attracting inadequate resources and personnel, a point acknowledged by Sir Keith Joseph (1973) when he was Secretary of State for Social Services. The very need for a hortatory article encouraging professional rehabilitation workers to take interest in the theory underlying the work that they are doing, is indicative of a prevailing atmosphere. (Hardy 1971)

Of studies of rehabilitation following cardiac disease, Croog et al. (1968) write "On the basis of our recent review of the literature in this area, it can be concluded that only minimal information is available." Since then, research undertaken by Gray, Reinhardt and Ward (1969) has been published. They investigated the use made of rehabilitation services by cardiac and other severely disabled patients. They confirmed their preliminary hypothesis that "one reason cardiovascular patients are rehabilitated less frequently than other disabled persons is their being less willing or able to accept their impairment realistically. While superficially their findings about the potential success of rehabilitating cardiac patients look impressive, their model is based on a now untenable totality of the concept of the sick role. This view leads them to state, for instance, "the cardiovascular patients...adopted the sick role less frequently than did the other disabled patients. This is an especially significant finding when it is considered that a person's willingness to adopt the sick role is usually a functional prerequisite to rehabilitation and treatment." Their report reads as a confirmation of their assumptions, without adequate testing.

These comments on research into rehabilitation have not only shown how little is yet known, but also have indicated some areas in which knowledge is urgently required. While the present study is not attempting to achieve any of the goals that have been set out, its interest is complementary, and in its focus on the social processes that characterise the stage of recovery, it may contribute to a

greater knowledge of formalised rehabilitation.

III. Institutions and Their Effects

Some consideration needs to be given to the relation between this study and the work that has been more specifically focused onto the ways that the structure and functioning of institutions affect the inmates. Goffman's (1961) now classic analysis of total institutions heralded what Jones (1967) has described as the 'literature of dysfunction'. Even when subsequent work, such as the Morris's (1965) on prisons, has investigated the inmates' responses to the institution the model of the unchanging institution imposing its influence has underlain the orientation. It is only comparatively recently that there has been any challenge to Goffman's implication that the effect of institutions is one-way and uniform. This work again tends to centre on the penal service and the most notable is Cohen and Taylor's (1972) work on long term prisoners. Although the 'extreme situation' that they studied was by definition one of very protracted time, they draw parallels with other situations of deprivation, disaster and social disruption, and much of this can also be seen to be applicable to hospitalisation where life itself is threatened. Their criticisms of the traditional sociological approach to institutions, selecting only those which are relevant to the present study, centre on, firstly the passivity of the inmate "whose adaptations - ingenious as they sometimes might be - are somewhat pathetic in nature.", and secondly "the depiction of subcultures, underlife and secondary adjustments tells us little about the meaning of such phenomena to the group concerned, and the way they can be used, manipulated or exploited in diverse ways". At about the same time as Cohen and Taylor published their work, a brief research report on the admission process to prison, carried out by Bradshaw, Emerson and Huxby (1972) "casts doubt on the general applicability of Goffman's hypothesis". This climate of study has not yet, however, reached the hospital setting to the same extent. Duff and Hollingshead (op.cit.) studied the "interrelations between the care hospitalised...patients receive and the social environment in which it is administered." While they acknowledged that "the sick person is the primary actor", the findings they present are largely screened through the administrative framework of American hospital

administration. Their aim of increasing "our knowledge of factors which have discernible effects on the care of sick persons" focuses less on the patients' experience than one might have hoped that it would. Stacey et al. (1970) in their study of children in hospital, are concerned with the conjunction of the family system and the hospital system. They set out as one of the propositions of their study that "His behaviour in hospital will be the combined result of the person he has become before entry and the impact upon him of the social system he encounters in hospital." This passivity of the patient within the system imposed on him is perhaps more understandable in the case of children.

The orientation to institutions which is being adopted in the present study focuses on the patient's struggles to make sense of the system into which he is absorbed in the process of his interaction with it. However dependent he may be, at the same time he is active in his membership of the hospital system, and the patient subsystem. When this view is set alongside the approach to illness as a process, the episode of hospitalisation and the future career of the patient are seen as related to each other.

This orientation places an emphasis on the socialising function of the hospital which is not usually fully recognised in theoretical studies of hospitals. Rosengren and Lefton (1969) take an extremely instrumental view of the hospital's sphere of concern with the short-stay, actually ill patient, which seems to follow a disease focused clinical model of diagnosis and repair. This view is set within a scheme for the classification of varying types of hospitals according to whether their intended impact of the patients' biographical career is longitudinal i.e. in social time, and/or lateral i.e. in social space. While saying that some types of hospital "attempt to intervene in the present and future life of their patients with varying scope and in varying intensity" and "attempt to make an imprint upon the kind of person the patient will be, both now and in later life", they then suggest that the interest of the general hospital dealing with acute illness "is highly specific and focused upon well-defined and technologically accessible disease entities. Although (it) may well take account of additional factors such as occupation, family life, age, sex, and so forth, the relevancy of these to the defined problem is either minimal or given a low priority in the hospital". (p.122-5)

Their contention is that in the acute hospital there is virtually no involvement of the patients' lateral or longitudinal biography. In a similar vein they state "that just as the general hospital does not induct its clients, neither does it 'out-duct' them" (p.148-their emphasis)

While the research data confirm that in practice, the general hospital may operate as though it held this limited view of its function with acutely ill patients, this is not the impression it intends to give, although the messages are contradictory. There are two major limitations to such a view. The first is a theoretical one, in which the stages of illness and recovery are a developing process of which only a short period of time is spent in the hospital. The impact of this brief introductory phase is however not only in the crisis of hospitalisation itself, but also in the influence it exerts over the remainder of the process. This influence is two-fold. On the one hand it projects forward a model of life-after-a-heart-attack, which it expects the patient to conform to. On the other hand, it gives the patient a picture of the seriousness of his illness and the appropriate sick role he should play, which he is then expected to move progressively away from. The second limitation to such a view of the hospital's function, is that whether or not it intends to socialise its patients or affect their lateral and longitudinal life, in their own perception it does in fact do this. In other words, patients are in practice socialised and expect the hospital to influence their future life style.

Parsons (1958) recognises that socialisation does occur and sees it as functional to the therapeutic process by reducing the alienation that is implied by segregating the ill-deviant from society and by making tolerable the dependency that the structure of the hospital imposes on him. King (op.cit.) also sees the patient as relatively passive within the structure of the hospital organisation, but by placing more emphasis on interaction between the hospital systems and the patient allows for a more dynamic exchange in which the patients' perceptions of his place within the structure can be seen to contribute to his experience.

An interesting approach to the socialisation of patients into a prolonged medical regime is offered in the medical view as to how the "benefits of hospital treatment" can be continued after inpatient care, in Mair and Harnett's section of

the Nuffield Provincial Hospital Trust study (1962) Further Studies in Hospital and Community. While the attitudes implied in their conclusions cannot necessarily be attributed to all doctors, they are extremely revealing. The Studies covered the inpatient treatment and two year follow-up of a sample of men admitted to certain hospitals in Scotland. Extracts from the conclusion of the study based in Dundee imply that most of the problems that occurred in the post-hospital period were the result of the patients' not following medical recommendations, which it was assumed had been clear and fully understood. "This transition period in which the patient returns to his normal environment and mode of living is a period in which much that is potentially preventable can befall him, and in which he is naturally more susceptible to relapse. It is impossible to estimate how much subsequent ill health would be spared the patient if all that is potentially preventable could be eradicated in this transition period, but the duration of benefit from hospital inpatient treatment could be prolonged." (p.139) They found that a significant variable in determining outcome was the type of disease process - which in the present research is controlled. They continue "Relevant to (the patients' agreement to use services) is the attitude of the patient regarding treatment or advice provided. The proportion of patients who failed in some way to comply with the regimen of treatment was relatively high. In some, this failure was attributable to a lack of knowledge of what was required. At the initial hospital interview, an assessment was made of the extent to which patients were aware of their disease condition, and the further treatment, including modification of way of life, which was advised. Over three-quarters of the patients were considered to have a reasonable appreciation of these aspects. In the early domiciliary visits, it became apparent that this appreciation was short-lived in a small number. The same was observed at later visits despite reiteration of advice given at the previous ones. In some chronic disease processes there is a time delay between neglect to comply with treatment and the effects of such neglect. Similarly, the effects of treatment are not always immediate.....Thus, despite all efforts some will lapse, it seems desirable that the patients should become as convinced as the doctor of the need for treatment or social adaptation." (p.140-141) The implication which seems to run through this passage and the surrounding paragraphs is that

doctors expect to be able to prescribe effectively for their patients' future and to include within their orbit such other aspects of the patients' lives as impinge on their health - their housing, work etc. The present research confirms that most patients share this expectation. The divergence occurs over how far there is real communication of that advice. Mair and Harnett seem surprised that "despite reiteration of advice" some patients did not seem to take it. The patients in the present study would lead one to ask questions about how far the advice was understood and seemed meaningful in everyday life. Many of them had reiterated "advice" - take it easy; slow down a bit; don't treat yourself like an invalid - which was extremely ambiguous in terms of health status and roles, and also very open to individual interpretation when they were genuinely trying to implement it. In these doctors' view, then, they saw themselves as influencing their patients but with the "failure" being mostly on the patients side. In criticising this approach from the data of the present research, it should be remembered that the voluntary element in inclusion in the sample may have resulted in a self-selecting-out of people who would later intentionally "fail to comply with the regimen." The criticism is based on the experience of many of my respondents whose intention was to abide by medical guidelines but who found the advice they were given was contradictory or meaningless, especially when it was set alongside influence and pressure from other sources. A number of them, although they were trying hard to "get it right" would probably have been classified by Mair and Harnett as "failures to comply."

These views of institutions and socialisation tend to echo Cohen and Taylor's (op.cit.) criticisms which have been outlined earlier. In order to redress some of this distortion, it is necessary to visualise the patients as, at least in part, creating their own socialising climate and using this to 'fill out' some of what the institution lacked. It is generally assumed that 'patient culture' is associated only with long-stay hospitals (King op.cit. Roth 1963) although this assumption is challenged in the data which will be presented. The discovery of the vitality of rapidly developed patient interaction and the significance that was attributed to it within a group of patients sharing the same diagnosis and being treated together has led to the formulation of the concept of a 'cardiac

culture'. The socialising implications of this cardiac culture, the patients ambivalent identification with in, and the ways in which they used it to create their own meanings and select their own paths, will be developed in the later parts of this thesis.

IV. Theories of the Family and Crisis.

The original conception of the research would have drawn heavily on some of the theoretical orientations towards the family. As it was set out in the first chapter, this view would have taken as its orientation, the dismemberment of a family unit when one member, the husband, was admitted to hospital and a new pattern of interaction and role allocation had to be established. This would have brought together a structural/functional approach to the family, such as that of Parsons and Bales (1956), Bell and Vogel (1968) and McIntyre (1966), and an interactionist approach, such as that of Hill (1949) and Schvaneveldt (1966). Both the changes within the family as a result of the crisis of illness and patterns of relating to the member who had been temporarily absorbed into another institutional system, would have been a primary focus.

However, the changes in the conception of the research which have been indicated meant that this body of literature became less immediately relevant. Although the family, personified mainly through the wife, is still seen as a major actor, the focus is not on a marital pair so much as on the wife as an important and intimate member of the husband's role-set. This reorientation accounts for the fact that the literature of the family is not being discussed at length now, and that theoretical models of the family will not feature in the analysis of the empirical data.

Whereas at first family theory and crisis theory were seen as closely related to each other in the research model, these have had to be separated as the concepts evolved. Theory about the effects of and handling of crisis, such as that formulated by Hansen and Hill (1964), Glasser and Glasser (1970), Rapoport (1962) etc, is essentially concerned with the crisis event itself and the immediate repercussions. The absence of any adequate theory of the later resolution of crisis was one of the stimuli influencing the second concept of the research model. The empirical chapter on the period of hospitalisation therefore, draws on the

theory of crisis, especially in terms of the perception of it and its change-inducing features, but there is no comparable formulation in existence to which the later stages can be related.

V. Process as a Concept for the Analysis of Behaviour in Illness.

The term process has been used in many different senses in the literature of medical sociology and of methodology. Suchman (1965) writes of five 'stages' through which a patient progresses in logical sequence. While this may suggest a norm of events, it is mechanistic and suggests little about the means by which the stages are successfully accomplished. Robinson (1971) is critical of Suchman's concept and expresses his discomfort with the term 'process', considering that it presumes both that there is but one process and that it is a 'whole process'. His main argument is the diversity of factors affecting the decisions made within families about the 'process of becoming ill'.

Yet a different use of the term is implied by Groog, Levine and Luxie (1968), without defining it. They write of their approach to the "recovery process" in heart disease, conceptualised as a response to crisis, having advantages as "It leads to a focusing of attention on the kinds of adaptive mechanisms which are employed by patients, as well as the resources which they call upon in coping with their illness. It directs attention to the stages of recovery and to the resources and coping mechanisms which patients use and require at each point." In their extensive review of the research literature, they divide their article into sections concerned with:- the phases of recovery, the patient and the recovery process (covering clinical, psychological and sick role studies), the physician and recovery, the family, work and the recovery process, and agencies and services. While a very large quantity of research is included within this framework, the end result is essentially an evaluative listing of the constituent elements of recovery, for which the term process seems inappropriate. While such a listing has value by placing in juxtaposition many orientations and theoretical models, its value as a source should not be confused with a contribution to the understanding of process.

In the context of a discussion of research methodology, George Brown (1973) comments on R. Brown's (1965) distinction "between the reasons for the occurrence

of something and the way it took place. Correspondingly, one has tasks of explanation and description. Description tells us how something looks for its own sake, before trying to explain it in terms of something else.Explanatory theory is directly concerned with causal processes: it asks whether something is responsible for something else". Later he says "it is not clear.....how far spelling out a sequence of stages in a social process leads to insights into what may be determining this process in the first place." His main use of the word process would seem to emphasise the interconnection between the factors in a situation, especially in seeking a cause and effect relationship.

Both because none of these uses of the word process seems appropriate and also as further confusion could be created by yet another unspecified orientation to it, some definition of the use of it in the present study would seem to be necessary. It is being taken to mean a descriptive analysis of the inter-relation of various facets of an individual's experience as he passes through a transition phase, relating the phases as he experiences them, and examining the means by which he achieves the many tasks presented to him as his status changes.

a) Convalescence as a process

This general definition may be given more meaning by relating it to the two dimensions of the experience of convalescence which will be referred to throughout this thesis; the longitudinal dimension and the lateral dimension. The longitudinal view traces the patient's experience through from the time of crisis, through improvement to recovery (or disability). While this sequence is still incomplete in that it can only view the pre-crisis behaviour retrospectively, it goes a long way towards meeting Robinson's (op.cit.p.106) objection that "By picking people up at one well defined stage it is possible, so the assumption (about stages) goes, to ask retrospective questions, fill in the other stages in the 'process' and thus arrive at an understanding of behaviour in the main illness situations." As the main focus of the present study is on convalescence it is appropriate that the research should have begun at the time of the crisis, although the practical difficulties, which have been indicated in the previous chapter, often render this impossible. This longitudinal time-span may mean that this study makes a contribution to the research need indicated by Greag et al. (op.cit.

p.126-7) - "The concept of the sick role is potentially highly useful in clarifying ways in which the social and cultural factors mediate the recovery process. Unfortunately, little empirical research has thus far been carried out in this area. Instead, the investigators have centred on such problems as differential definitions of the sick role and on those situational and psychological factors which help determine entry into it. One possible line of investigation might concern ways in which differing definitions of the sick role relate to the illness behaviour of those persons who become patients. There is ample evidence that norms regarding appropriate behaviour in the sick role vary among sub-groups in the population. Some groups tolerate or even encourage prolonged dependency in the sick role while others do not. Thus, one area for empirical study might involve the question of the possible relationships between (a) differential conceptions on the part of significant others and (b) patterns of recovery or rehabilitation on the part of the patients. More specifically, in what ways is variation in norms associated with the sick role related to the course of recovery or rehabilitation of heart patients?" This view demands a longitudinal approach which can at least explore the interconnection of the phases of the experience.

The lateral view of illness and recovery as a process is partly included in the quotation from Crogg et al. above. They make reference to "significant others" and the concept of the individual patient constantly interacting with both his pre-illness and his newly-acquired role-set is a central theme of this thesis. But the lateral dimension is taken to mean even more than this; each person occupies his own unique range of 'social space' - his personal repertoire of activities, roles and relationships, whether from choice or because they are imposed on him. The lateral process of convalescence must therefore include an examination of the decisions he must make about the effect of the illness on his 'social space', and the means by which these choices are made. These two aspects of the lateral view are in practice almost inseparable except when artificially disentangled for theoretical analysis, and both are closely interwoven with the longitudinal dimension. The following chapters of the thesis will elaborate this concept of convalescence as a process, and the longitudinal and lateral dimensions

will be traced throughout it. The longitudinal view can be likened to photographing the same scene, but altering the camera's range of focus; when the patients were in hospital, their experience and the events connected with it were in sharp focus and their future convalescence was rather blurred in their distant vision; later, the focus could change to what had been distant but was then of immediate concern, and the hospital, while still featuring in the picture was more blurred. While no analogy can ever be worked out in all points, this longitudinal concept seeks to emphasise the essential continuity of each patient's experience with its sequence of events and illnesses from which meaning had to be extracted. Because the ordering of the data so that they might be analysed and discussed has inevitably tended to cut across this continuity, the point is being elaborated here at some length and will be stressed again. It is also hoped that the inclusion of a complete case study will help towards maintaining this focus.

The lateral dimension of the process is more easily reflected in the following chapters as this was of immediate concern to the patients at each stage, i.e. during hospitalisation and increasingly during convalescence. It will be discussed in terms of the reciprocal influences with their role-set, and the use that they made of these influences in evolving their own model as to how they should proceed through the convalescent period. Their decision-making over the range of their appropriate activities will be seen to relate both to their view of the process as a whole and to the intrinsic factors of discrete decisions.

b) Relation to other studies on post-myocardial infarction.

Georg et al.⁵ (op.cit.) review of the research literature, which was published in 1968, cites three hundred and forty seven sources either directly concerned with myocardial infarction or theoretically relevant to the study of it. The volume of work published since that date testifies to the continuing interest of social scientists, and perhaps also to the selection of projects approved by research-funding organisations. Coronary disease has a high rating of a scale of emotive social issues. Some of these studies would appear at first sight to have covered the ground investigated in the present research, in that they have followed the progress of men discharged from hospital following myocardial infarction, but the papers that are available (which it is recognised may not represent the full scope

of the studies indicate that only one segment of the resolution of illness had been covered. Reporting on his study, for instance, Garzity (1973 a and b) has written on vocational adjustment and social involvement of men after heart attacks; Monteiro (1973) has reported on her findings of behavioural expectations of those with heart disease. While these present well documented findings which are interpreted in the light of existing or proposed concepts, their contribution seems to be fragmentary when more fundamental issues remain so clouded.

Three pieces of research currently in progress in Scotland and not yet published are investigating these more fundamental aspects of the impact and resolution of acute cardiac illness. In design and purpose, these would seem to be closer to the first two conceptions of the present research than to its present focus, and when published, will, probably complement it with further insights into perceptions and with classified data. At the present time, only preliminary drafts or working papers are available, which are not at a stage to be quoted. It may however be noted that many aspects of their findings would seem to be in harmony with the data of my own study and it is expected that in general they will confirm that the experience of my sample has relevance to a wider population.

While strictly clinical-medical studies, such as those summarized by Syme and Reeder (1967) and recent reports on the medical controversy over cessation, such as Thompson (1974) are not being considered, it is recognised that some sociologically orientated studies of aetiology have got a potential relevance; (e.g. Hinkle (1967), Paul et al. (1963), Matsumoto (1971)). Similarly, psychological studies which differentiate survivors and non-survivors of myocardial infarction could add a further dimension (e.g. Ekman et al. 1964). Yet a line has had to be drawn, even if arbitrarily, as to how wide the scope of the present study could be and it has been necessary in order to maintain the focus on the patients' perceptions to omit these areas.

While it has been necessary to indicate something of the range of studies that have focused on myocardial infarction, some explanation must be offered as to why so few of them will be referred to again in either theoretical or empirical chapters. These studies are, in general, presenting data and concepts the substantive content of which is exclusive to myocardial infarction. The present study

has limited comparability, not only because it presents almost no quantifiable data, but also because the data collected were less concerned with classifiable facts than with the experience of process. This contrast reemphasises the point made in the first chapter about the central importance of methodology; that the orientation of any piece of research cannot be separated from the findings that it presents. While the present research proposes a theoretical framework which encompasses many of these studies, it also holds the potential for generalization into other types of illness. Its orientation is as much if not more to the study of patient biography and behaviour as to the study of cardiac disease. If, therefore, these studies, when they are available, are shown to have a positivist and/or extremely specific to myocardial infarction orientation, they will be interesting parallels rather than duplication.

In proposing that the theory that has been developed about convalescence after myocardial infarction may have potential for generalisation to other substantive areas, note is taken of Glesner and Strauss's (1967) warning. In differentiating two levels of theory, they write "By substantive theory, we mean that developed for a substantive, or empirical, area of sociological inquiry.... By formal theory, we mean that developed for a formal, or conceptual, area of sociological inquiry.... Substantive and formal theories exist on distinguishable levels of generality, which differ only in terms of degree.... With the focus on a substantive area.. the generation of theory can be achieved by a comparative analysis between or among groups within the same substantive area..... If the focus were on formal theory, then the comparative analysis would be made among different kinds of substantive cases which fall within the formal area." (p.32-3) They warn of the danger of "'rewriting' techniques for advancing a substantive to a formal theory. The sociologist can simply omit substantive words, phrases or adjectives..... Such rewriting techniques applied to a substantive theory produce only an adequate start toward a formal theory, not an adequate formal theory itself.... All they have done is to raise the conceptual level of their work mechanically; they have not raised it through comparative understanding. They have done nothing to broaden the scope of their theory on a formal level by comparative understanding of different substantive areas." (p.80-1) Thus, while

the theory to be presented is kept closely related to its substantive area, the potential points for generalisation, which would need to be tested in comparative studies, will be drawn together in the final conclusions. The most immediate sphere for comparison is with studies of other medical conditions, thereby contributing to the theoretical foundations of medical sociology. As already indicated, this would be likely to look towards both situations of acute illness and recovery, and also towards chronic conditions and rehabilitation. Comparisons with non-medical parallel situations may perhaps be sought in situations such as bereavement or occupational redundancy, both involving status transitions and a process of crisis resolution. Such comparisons will in future highlight which aspects of a substantive theory about cardiac convalescence are useful for a formal theory.

VI. Summary and Outline of Research.

The fragmented structure of this chapter reflects the characteristics of the material that has been discussed. The literature, theories and concepts that have been referred to are to a great extent compartmentalised and some have been shown to have inadequacies or gaps. An attempt has been made to depict the genealogy of the present research, and in the process to distinguish between its legitimate and putative parentage. That much of the comment has been critical is a direct result of the nature of phenomenological research which will not allow the exploration of the 'real world' to be forced through a channel of preconceived ideas, however respected these may be.

In this way, the orientation of the research unites these first two chapters, in that they have set out the basis of the study and shown how this contrasts with other work. Without it, the reader would not be in a position to evaluate the significance of the material that will be presented. The theory and practice of the research have been discussed and related to the theme and substantive area which is under study.

The structure of the report, that grows from these foundations, is organised in such a way as to emphasise the interdependence of theory and empirical data. Although the material has been divided into two time periods, the hospital and the convalescent, the longitudinal aspect of the process emphasises the inherent

continuity; the lateral aspect, which gains increasing significance as the longitudinal proceeds, has its emphasis balanced accordingly. Chapter 3 presents the empirical data on the patients' hospitalization, examining the ways in which this influences their experience of being a cardiac patient and prepares them for recovery. Chapter 4 introduces a theory of convalescent behaviour. This is the conceptual model which has emerged from the analysis of the data, but which is being presented before the remainder of the empirical data so that the theoretical constructs may be explored as an interrelated whole and then referred to as each part of this whole is relevant in the data analysis. This theory is then worked out in the following chapters; chapter 5 considers the model of convalescent behaviour presented to the patient by influential people in his role-set; chapter 6 discusses the wives' views of convalescence and the ways they affect their husbands' experience. Chapter 7 examines both the patients' own experiences of convalescence and the ways they mediate these varying influences to decide on their own individual version of it. The conclusions seek to draw these themes together and suggest questions relevant to future research.

3. THE CRISIS AND AGENTS OF SOCIALISATION.

A longitudinal view of a patient's career through illness logically demands an examination of the path of entry to that career and the initial socialisation into it. Although some information, of a retrospective nature, is available on the events leading up to the time of hospitalisation, most of this chapter will discuss the patients' perceptions of the crisis of illness as they were influenced by the members of his role-set. This introduces the empirical aspects of the early stages of the longitudinal and lateral dimensions which have been discussed theoretically in the previous chapter. The interdependence of the patients' own perceptions with those of other people will be seen in the context of the hospital and be viewed as his initiation into his future as a cardiac patient.

Admission to hospital - a prologue to the first scene.

Whatever the events and time period of symptoms that had preceded the admission to hospital, once the decision had been made, action followed very rapidly. The speed with which events followed one another, and the procedures surrounding the patients' admission into the hospital were understood by them to indicate that their illness was being considered an acute medical emergency. King (1968) in his analysis of the hospital as a complex organisation, points out that its structure and systems of authority are tuned to handling emergencies with efficiency and the minimum of staff anxiety; each member of staff knowing their function in keeping procedures operating smoothly. This efficiency and atmosphere of staff confidence is very reassuring to the patient experiencing hospital treatment for the first time.

However, the messages conveyed through these admission procedures are complex and contradictory. On the one hand, the staffs' competence encourages the patient to trust them and be dependent; an attitude which is quickly reinforced when the doctor acts to ease his pain, thus demonstrating that his illness is treatable. At the same time, the manner of his admission indicates to him that his illness is very serious and that emergency procedures are being used. These themes with the inherent tensions that they imply, will be seen to continue although changing in emphasis throughout his inpatient stay and into the future when he becomes a convalescent.

From the patients' point of view, the acute onset of his illness and his admission to hospital are experienced as a crisis which redefines his present status, implies threat to his survival and, if he survives, will result in radical changes in the future. His admission to hospital is therefore crucial both in ensuring that there is a future for him and in his expectation that he will be guided as to the form of his future life. Once he begins to have confidence that he will survive the illness, he becomes concerned to find models for his future life-style. In this way, the process of recovery starts very early and is developmental as he becomes increasingly focused onto his future.

I. The Role-set.

In order to understand the patients' experience of socialisation into being a heart-attack patient, it is necessary to discuss those groups of people who influence his experience and who present models of the ways he should conduct himself both while in hospital and in the future. The four units of his role-set which were of significance throughout his recovery were:- the hospital, as an organisation into which he had been absorbed and which was personified to him in the medical and nursing staff; his wife and immediate family; the 'cardiac wise';* and 'others who express concern'. It will be seen that this role-set is a combination of pre-illness and newly acquired relationships. Each of these will now be studied separately to examine the contribution that they make to this stage of the patients' career, bearing in mind that the units of the role-set had some interaction, and also that the influence that they intended to exert may or may not be similar to the influence the patients experienced.

a) ^{members of the} The hospital.

Among the several segments of the patients' role-set, the ^{members of the} hospital seemed to take a place of primary importance during the early stages of his illness. It is hard to substantiate this statement with verbal evidence from the interviews as it

*Footnote. While apparently similar to Goffman's term as he uses it in 'Stigma' (1963), the meaning given to it in the present context is that of people knowledgeable about cardiac illness because they themselves had had experience of it.

was implied in much of what the patients talked about but seemed so self-evident that they felt it almost irrelevant to put it into words. To accept it as a statement of fact would seem to accord with Parson's (1951) view of the sick role as a primary role, superceding all others. In this sense, the hospital was acting as the major definer of the patients' situation and as the setting within which they experienced it. In order to understand the impact that it had on the patients, it is necessary first to distinguish between the physical/organisational characteristics of the hospital and ^{the} personnel who acted towards the patients within this context. After a brief outline of these, which offer a description of the scene, the patients' experiences of them will be discussed, firstly under the same two groupings and then as the organisation and personnel are perceived in interaction.

a.1) Physical/organisational ^{context} aspects.

The organisation of patient care in the hospital where the research was carried out is not necessarily typical of all hospitals. It is a modern district general hospital within a group of hospitals. The range of Casualty and Accident emergency work is based at one of the other hospitals, so that the patients who are sent to this particular hospital have already been classified by the referring agent (G.P. or factory nurse) as acute medical emergencies for whom admission to hospital is anticipated. The patients who arrive by ambulance are seen as emergency admissions, and, after preliminary investigations have confirmed the provisional diagnosis of myocardial infarction, they are transferred to the ward. All the patients seen in this study were admitted to the Coronary Care Unit (C.C.U.) which formed a self-contained unit within one of the wards on the medical floor. The Unit was in two sections. The part to which the patients were first admitted was equipped with continuous electrocardiograph machinery for each bed. The patient as he lay in his bed had this machinery attached to him by pads fixed to his chest, the flexes of which led to the machine. He had considerable but not unlimited freedom of movement within his bed to alter his position. The machinery projected a visual image of the speed and nature of his heart's performance onto a 'television screen' both beside his bed (but in a position where he could not see it without turning round) and also onto a master screen at the nurses desk.

During this time the patient was also frequently receiving an intra-venous infusion (a drip) into his arm or hand. The patients remained in this section while it was necessary to continue to monitor their cardiac function - or until the bed with the special facilities was needed for a newly admitted patient - and were then moved to the other section of the Unit. While there, which lasted for a time of hours to a few days, they continued to be cared for by the same staff. They were then transferred for the remainder of their inpatient care to another ward on the medical floor.

The features of this that require some discussion are; firstly that the unit is small and has a high staff-patient ratio. Patients interact with some intensity with the feeling of a shared threat and the intimacy of the setting thus provides fertile ground for the development of a cardiac culture, which will be discussed later. There is an air of continuous activity, which while it made rest difficult for the patients, also meant that they felt cared for and safe. To an outside observer, there was no atmosphere of tension. For the patients, though, there was frequently a sense of an atmosphere of incipient crisis. After one patient had died in the unit, Mr. Fraser said "At the time I was a little bit frightened - I think, well, two of the lads here might be bleeping (the noise the monitor makes when there is a significant change in the pattern of the heart beat) and I couldn't see if it was mine. I started to sweat and they say 'Whose is it?'. Almost every patient spoke spontaneously of the very high quality of nursing care that they received in the unit. Secondly, a newly admitted patient soon realises from observing other patients, that transfer from one ward to another is the normal procedure. Mr. Eaton said "I think right from the start in here you realise that you are highly mobile. You come in and you are put on a bed and within two minutes you could be anywhere" (16). It may be that the group setting prepares patients for these transfers and this minimises some of the adverse effects of progressive coronary care that were found by Klein et al. (1968). The patients' perceptions of these features will be discussed later.

a.2) Personnel

The personnel of the hospital that relate directly with the patient going into this Unit are the doctors, the nurses and the dietician. The organisation of

the medical staff is somewhat complex as two teams of doctors are involved; one being primarily in charge of the C.C.U. and the other assuming care of the patient on the general wards and after discharge. The nursing staff, as has already been indicated, are more numerous than in other parts of the hospital. Their tasks are both highly technical and also demanding of a great deal of bedside nursing care to the very ill and very dependent patients. Some patients persuaded the Sister in Charge to give them some information about their illness and treatment, but the other nurses seemed to observe the custom of refusing to answer or deflecting questions. On the less acute wards to which the patients were transferred, there was a lower nurse/patient ratio, and the patients were expected to undertake much more self-care.

The dietician visited most patients once or twice during their stay. The way that the patients spoke of her implied that these visits had significance for them in so far as she made real the restrictions that they disliked. Because of the nature of her task, her authority tended to be seen in a negative light.

a.3) Patients' perceptions of the organisation.

When turning to the patients' experience and perceptions of the impact that the hospital had on them, the structure and the personnel will again be discussed separately, before the two are brought together.

The days spent in the C.C.U. were characterised mainly by the subjective feeling of being very ill and usually very frightened. The 'totality' (Goffman 1964) of the institutional setting gave a sense of security and its limited permeability to outside influences was a source of protection. Even once the pain and sense of critical illness had eased, many patients still had a great deal of anxiety and were content to be extremely passive. In this way, they accepted without question the authority of the setting to dictate their treatment and control the details of their lives.

At this stage, a high degree of dependence was expressed in some form by most of the men. This dependence seemed to them to 'match' the benevolent authority and competence around them. The relief that was experienced by admission to the hospital was expressed by Mr. Keoghan as "Fright is part of it."

You don't know what is happening to you. At the time I didn't think I was going to die - I knew once I could get to hospital I'd be all right". Mr. Oliver put it "I was frightened anyone who says they're not frightened is telling a lie. I thought I'd die It felt easier when I got to the hospital and had the injection even after the pain had gone, I felt wary. I began to get my confidence back when I got in here (C.C.U.)". Mr. Fraser - "I know they're doing everything they can and I'm in the right place". Mr. Easton - "Once I was in here I felt everything was under control". The use of the term "the experts" was a recurring one. Mr. Dodds felt confident because "the specialists are dealing with this day in and day out". Mr. Easton - "...if you go to experts and put yourself in their hands, you take the expert's advice". Although for some people the monitor was a source of anxiety, it could also be comforting; Mr. Keoghan put it - "I was glad (of it) because they could keep a check on me it was a safe feeling they kept checking you all the while". Mr. Oliver was more detached - "I mind it in a way, but it's necessary I watch it".

The patients' evaluation of themselves when they were in the Unit was summed up by Mr. Hewitt on the day that he moved from the monitor room to the less intensive care part of the Unit. "But they're more important there than you are here - they will be if they're heart cases - they're bound to be. Especially if you're past your stage and they're on the critical stage, they're bound to be more important than anyone else". In view of the fact that this self-definition was closely connected with the use of the monitor and the intensity of care, it was interesting that the two patients who were moved from that room because they said that the bed was needed for a patient more ill than themselves seemed to accept this philosophically and with little anxiety. In view of the significance of the moves as marking stages of progress (which will be discussed later) it might be suggested this was surprising. It seems possible that it was an early manifestation of their identification with the 'cardiac culture' in which the very best care had to be given to the critically ill patient.

Once on the general medical wards, the patients had to get used to a completely new set of nurses, and had to share them with many more patients. There was also a diversity of kinds of illness being treated and less consensus about the regime that they were supposed to be following. They welcomed and often sought out opportunities to maintain contact with other patients who had been in the C.C.U. with them, as though seeking to consolidate the fraternity of the 'cardiac culture'. They were also more open to outside influences, and at this time 'the wise' among their outside contacts became more significant. All these things meant that they were exposed to much more varied and often contradictory influences, which not only caused some confusion but for some people resulted in considerable anxiety.

a.4) Patients' perceptions of personnel.

In turning to the patients' perceptions of the staff, it is again useful to separate nurses and doctors. The unqualified praise of the nurses in the C.C.U., which has already been referred to, must be seen in this context as indicating more than a measure of the excellence of the nursing care, though without detracting from it. The state of dependency that the patients were experiencing was being made tolerable for them because the service that they received matched the need that they felt. While it can be argued that extensive nursing care also fosters dependency, this, understandably was not the way that the patients expressed it. Mr. Easton in looking back at his time in hospital said "Virtually, in hospital you have no views in that intensive unit - every whim is looked after". Their appreciation became more specific after they had moved to the other wards and had a different style of nursing with which to compare the Unit.

Once on the general wards, the patients were less physically dependent, but sometimes expressed covert anger. Mr. Fraser - "This ward isn't so well organised for my diet. The discipline of the place seems to lose out down on this side. May be psychologically a good thing - You've got to tell them the routine yourself... It rather surprised me the efficiency there is over that side (C.C.U.) and it rather deteriorates. No disrespect to the nurses and that". While the ending of the special nurse-patient relationship might be resented, for some patients this could be seen (perhaps as a rationalisation) as an indication of their progress

and a purposeful stage towards recovery. The rationale of progressive patient care was, however, not explained to the patients; they had to infer it from their observations.

The decisive action that the doctors had to take in the acute early stage of the illness was seen by the patients as very reassuring. The only things that they wanted to know at this stage was what was wrong and whether the treatment would be effective. However, as the situation changed with the passage of time, the possibility of a different type of interaction was introduced.

Most theoretical formulations about the doctor/patient relationship are based on a psychiatric or psychotherapeutic context of treatment. However Bloom (1963) criticises Szasz and Hollender's (1956) attempts to set the relationship within the context of physical illness as being too reliant on categorisation of the severity of the illness, as being mechanistic and because it focuses on the doctor/patient dyad to the exclusion of group and cultural influences. While recognising some of these limitations, it can still have something useful to contribute to the present discussion. To summarise Szasz and Hollender's concept, they set out three typologies of doctor/patient relationship. 1. Activity - Passivity. In this the doctor is active and does something while the patient is so acutely ill as to be completely helpless. This parallels the parent/baby relationship. 2. Guidance - Co-operation. These patients are less acutely ill and are capable of exercising some judgement and following directions. The patient is expected to respect and obey the doctor. This parallels a parent/adolescent relationship. 3. Mutual Participation. This is proposed for chronic illness when the treatment programme is to be carried out by the patient with occasional consultation with a doctor. This parallels the adult/adult relationship, the one having specialised knowledge. If this is used 'in the flat', I would agree that it offers little more than a one-dimensional view of very complex interaction. If, though, other dimensions are added to it, it is more dynamic and has a greater richness. The first dimension to be added is in harmony with the central theme of this thesis, that is, one of process. The illness of coronary thrombosis follows very closely in its successive stages the types of medical

situations to which Szasz and Hollander relate their types. The corollary for this would be to look for progression through the types of relationship which kept in step with the changes occurring in the illness and its treatment. The second dimension which could open a useful avenue for analysis would be to introduce the concepts of congruity and incongruity. This would make possible a frame for understanding some of the stresses and sense of inadequate communication which are frequently reported especially from the patients' point of view. Some of the patients interviewed seemed, for instance, to wish to relate to their doctor in the later stages of their illness as in Type 3 while their doctor still seemed to be operating on Type 2. Others seemed to want to remain at Type 2, while their doctor was perhaps implementing a kind of Type 3. It also seems that both parties to the relationship may convey contradictory messages about their expectations, which are also, as Bloom rightly points out, subject to influences from outside the dyad.

The research data cannot substantiate these ideas very conclusively, but certainly suggest that this may be a profitable line of approach.

Whether or not a future study confirms any value in these ideas, certain observations can be made from the data of the present research. The patients and wives with whom the staff communicated fully, appreciated it. Mrs. Archer said "The doctors have explained everything to me and my husband, for instance about the pacemaker....I helps me, to understand....all this equipment could have been very frightening had Dr.A not been so good and explained". Many expected the staff to take the initiative over giving information. Mrs. Fraser didn't like asking questions and spoke gratefully of "one staff nurse who took the trouble to say anything without being asked". Her husband had a similar sort of approach "I don't ask too many questions because they've got a lot to do and I think if there's anything wrong, they should tell me. I don't know if they do" and again later, as if still bothered about it - "I'm not the type to ask because that's his job - he can tell me. I think this, if there had been something seriously wrong with me I'm sure he would have said 'Well, Mr. Fraser, we've got to keep you here so-and-so' But he hasn't said anything like that so I can only assume, if he's as honest as I am, that he'd tell me". Mr. Jessop was one who

felt that he was not told enough even though he asked, in other words, he wanted a Type 3 communication but did not receive it, - he tried to mute his anger; "They've obviously got their reasons, but a little bit of enlightenment wouldn't hurt - When you're in hospital you're always needing something to boost your ego - to make you think you're nearer the front door. They could have said to me...." These comments all referred to information about the illness itself and the time in hospital. The other main area in which information was wanted concerned the future, both as a prescription for behaviour during the convalescent period and as a definition of the health status which he could ultimately hope to achieve. Again, not everyone's expectations were similar, nor were their experiences. Mr. Fraser, who has just been quoted over his reluctance to ask, hoped to be given very detailed instructions - "If he says I haven't got to do A B C D, I shan't do A B C D. I won't attempt to do it, because I'm that way made. But if he says I can do E F G H - I shall do them". He was very pleased when the doctor set out a programme for the stages of his recovery and felt that this was very clear to him. A week after his discharge, though, it had become more problematic and confusing. "He told me that before (I left hospital). I just resigned myself to relaxing. He'll tell me when I'm ready. I'm getting fed up to the teeth now. I said to him 'It'll be two months before...'. He said 'No, one month - to get you back to normal'. I thought he said two months - he said I would be normal and back at work in two months. But I did ask him 'Two months?' He said 'No, one month to get you right'. I'm sure he had said two months and you should be back to normal". There is no way of clarifying whether the doctor's statement had changed or whether Mr. Fraser had misunderstood the intended communication. Either way, the result was confusion.

Mr. and Mrs. Langton were both anxious to get specific instructions before he was discharged - they said this about the events on the day of his discharge:- Her. "Finally, it all seemed to be a bit too much of a rushI knew he was seeing the doctor and I'd made a real effort to get to the hospital for 11 o'clock (the beginning of visiting time) - I literally timed it downstairs - I stood there for about ten minutes - and at one minute to 11 I was in the lift - and even then I was too late - He'd seen him. I didn't see the doctor. Here again I was rather

disappointed because I was under the impression that he had said to me on the second day, that he would discuss it again before he went out. I was left up in the air 'You're all right now - Carry on'. I was a bit baffled reallyI think he fell down on this. - But I think perhaps I ought to have been a bit more positive about this".

Him. "I thought he might have said a little bit more to me - I had no instructions as to how I should look after myself when I got home, etc."

Her. "This again, I expected....I thought, my husband's an intelligent man, he'll have the message, I don't need to be standing beside him. But he hadn't got the message and this rather surprised me".

Him. "The only little bit of information I got was from the Sister. Dr. C more or less dashed off. I didn't know anything about the diet - this hadn't been discussed and I was on a reduced diet while I was in hospital. The only little bit of information I got was from Sister when I went to see her - I said 'Are there any instructions for me - what about diet and so on?' She said 'There's no need to diet at all. No other instructions'".

Subsequent events in this family showed how, in the absence of definite instructions, they tried to make concrete some very general comments that had been made by the consultant when he was first admitted - but experienced immense anxiety in the process. So strong were their feelings about the inadequacy of the staff's communication, that, in looking back over their experience, they wanted to suggest ways of improving the situation for other people. "I want to stress the need for the doctor to tell....If he could set aside one hour a week and have a kind of class where everyone could listen. I suppose it's too much to hope that they could give half an hour individually to you to explain." ; and again "There's a good case here for a centre of a get-together - a club of some sort where one could be addressed by a heart specialist and given some good advice."

To summarise this section on patients' perceptions of communication with the medical staff, it is striking that everyone of them wanted a model for their future. Those who thought at the time that they had been given adequate guidelines, found that these were difficult to implement in daily life, others thought they had inadequate guidance and sought to make definite the general outlines that they

had picked up.

a.5) Effect of organisation and personnel on the patients.

Although so far the patients' experience has been considered separately under structure and personnel, it is now valuable to bring these two aspects together to consider the effect of their interaction on the patients. This analysis reveals some fundamental contradictions in the messages the hospital was conveying which will be discussed in three related areas, those of health status, and progress and activity.

Firstly, in offering definitions of health status, the messages were confused. It has already been indicated that on admission, the patient was presented with two views of his situation. He was very ill - he needed and would receive urgent treatment, he would be cared for in a special unit with sophisticated equipment. But also, he had no need to worry - the staff found his condition perfectly manageable and could cope with it. Within hours, or at least the first day, he was told that he had had a heart attack - a diagnosis which was always treated by the patients as serious. Mr. Neale said "It's a frightening experience when you know what it is. So long as you don't know what it is, it's not so bad. When you know....it makes you think twice....The doctor was pleased with me this morning. He said if I carry out all the instructions, I should have nothing to worry about." Similarly, Mr. Berry "I didn't think it was a heart pain - I would have been scared if I had known - I didn't know until I'd been in hospital a while and my wife asked. It reminded me of my brother (who had died of a heart attack) and I remembered that he had had chest pain. But his was worse than mine." For other patients, the giving of a diagnosis was a relief, because if the doctors could label his trouble, it showed that they knew about it.

The patients almost all felt much better after their first few days in hospital, but did not know how far to trust their subjective experience. It was at this time that they seemed to become much more dependent on the doctors to give them statements about their health. Mr. Hewitt put it "The doctor asked me 'How are you' I said 'As fit as a fiddle'. He laughed. I said 'I say I'm as fit as a fiddle - I've got to go by you people'. So he examined me and said 'You're right'". This interchange occurred on the fourth day of his time in hospital -

the doctor was agreeing that he was 'as fit as a fiddle', but he had only moved off the monitor a few hours before and was still in the C.C.U.; his activity was to continue to be restricted very rigidly for several days and he got into trouble immediately after the doctors' round for getting out of bed to go to talk to another patient. A recurring phrase used by almost all the patients was "The doctor is pleased with me" or "He thinks I'm doing all right." Mr. Langton said "I'm much better, I'm feeling quite well in myself. Everyone else seems quite happy with my progress - so I'm taking it as it comes."

While the doctors' reassurances about their health seemed quite satisfying in the early stages, more confusion seemed to be introduced in the later stages of their time in hospital. The perceived contradiction then was extensive reassurance about their progress on the one hand coupled with apparent indifference to any further episodes of chest pain that they experienced. Many patients had episodes of pain, which they found extremely frightening as they resembled the pain of the initial heart attack. Mr. Jessop had an episode of pain shortly before he was due to be discharged. "It frightened me a little....Well, I'm not back to square one, because I'm a lot better than what I was, but...." After having pain, Mr. Keoghan said "It's been a warning to me last night how serious it has been - I thought it was just something trivial.... the doctor didn't really tell me a lot about what happened - but he did say 'you know, your heart has taken a bit of a bashing' - whatever he meant by that." For these men, therefore, the occurrence of further chest pain was an unwelcome qualification to the reassurances they had been given; one which shook their growing confidence, especially as it seemed to them to be lightly regarded by the staff. There was often then, confusion as to how to understand it and what weight should be given to it in their definition of their health - the pain had signaled danger and emergency at the beginning and now apparently it did not do so. In the struggle to understand it, they expressed relief at the fact that they were still in hospital - Mr. Dodds - "It felt safer there. You can turn to someone else, and he's got a pain in his chest and I've got a pain in my chest and so what? You know if you have another attack you're only as far away as the bell that you ring to fetch the nurse." This difficulty of understanding the relevance of pain to the

definition of their health status and their progress continued to bother many of the men once they had left hospital. There seems to be reason to think that if it had been differently handled during their time in hospital, this aspect of the ambiguity of their convalescence could have been less fraught with anxiety.

Secondly, the patients' attempts to understand their progress were also related to the interchange between the staff and the structure. Through familiarity with the successive stages of treatment, the staff did not necessarily think it was important to explain to the patients why changes took place. It has already been suggested that patients learnt of procedures from other patients, but in this context, it must be seen in more individual significance. Whether or not it was reinforced by verbal communication, the patients attributed significance to staff actions and interpreted these as redefinitions of their health and progress. The first event to happen which was defined as indicating progress by nearly all the men was when they were taken off the monitor. Mr. Keoghan - "I knew I must be getting well - it was a good sign really." Mr. Gould - "It was a great relief to be off the monitor - you know why you are on it.....you're wondering if you are going to have another one or not." Mrs. Dodds - "(the frightening stage was over) when he got off the machine. He seemed more relaxed and I felt more relaxed. I felt, well, he's off the machine, and he must be O.K." Mr. Heale - "It gives you confidence, because you know you must be getting better." The story was the same from many others. Sometimes the action was reinforced by verbal reassurance, but even when it was not, it was seen to speak clearly about his progress.

Immediately, or very soon after the patients were detached from the monitor, they began a series of ward changes as is usual in a system of progressive patient care. Although some patients were aware that the timing of their moves was being dictated by the availability of beds, yet they still saw it as an indication of their progress. Mr. Jessop who had felt "a beast" and "an exhilarating feeling" about coming off the monitor, knew that it had happened at that time because "there was an urgent patient come in and I was

one of three patients that was progressing most favourable." Four days after this comment, he said "Psychologically I knew once they moved me down here (general ward), I was getting better." Three days later, after he had been frightened by an episode of pain, he was moved onto yet another ward with no explanation. His reaction then was "This is the confusing part, the continual moving....They've obviously got their reasons, but a little bit of enlightenment wouldn't hurt....Whether having the pain is anything to do with me being whipped round here, I don't know....If only they told you more, such as 'You're getting on O.K. and we've moved you round here for such and such a purpose' - it would make a lot of difference." What seemed to happen in Mr. Jessop's experience was that the early actions seemed to him to be reassuring and congruous with the other cues he was receiving about his progress. His confidence in his steady progress had been shaken by the episode of pain which had not been explained to him, and a move following soon after this raised questions rather than confirmed trust. He had, in other words, learnt to interpret staff decisions as meaningful, and suddenly they seemed to him to be confusing.

Thirdly, in addition to using the hospital system to meet his needs of understanding his health and progress, many patients also took as meaningful the function of the hospital in determining their activity. They progressed through stages starting with total bed-rest, to sitting out of bed, to walking to the bathroom, to, eventually for some, freedom to walk up and down the corridors. Mr. Barton's progress was rapid once he got to the general ward. "Yesterday I was able to get out of bed and potter around the bed. Today I've been able to go down to the dining room (along the corridor) for my meals and I got permission to have a bath this morning - you know one of the chappies kept an eye. I'm going to be moving more and more now. I'm restricted to the confines, but I can come and go." Mr. Langton was rather hesitant about progressing too fast - "I haven't pushed myself at all - just keeping within the limit of things....I think I'm probably taking more rest than I really need. Whether that's a good thing I don't know, but I might as well take advantage of it." Later he said about

the shortage of nurses, "This is probably a good thing - part of the cure - it makes us do a little for ourselves." Mr. Keeghan, after a bad episode of pain, didn't find the policy so easy to accept, although he still thought it's message was clear - "Around here - the nurses like you to help yourself. You don't get the same attention, like on the C.C.U."

While this stage of improving health but restricted activity could have been used very profitably as a period of socialisation into the later stage of convalescence, in practice it contained the very elements of uncertainty and ambiguity that were going to characterise their post-discharge period. The staff were reassuring about their health and very optimistic about the future, but at the same time set restrictions which were frequently not discussed. When the 'rules' were set in very general terms, the patients often did not know that they were 'disobeying' until they were found out. Mr. Mears's experience of this was - "Yesterday I took a bit of a liberty. I was expecting the wife to come and I thought I'd shave before she came and before the doctor came round. So I went in the bathroom and while I was there the doctor came and he called me out and he said 'Look, I wish you wouldn't do that - you haven't permission to go and wash.' I said 'I'm very sorry about that. I didn't know and I wanted to go and shave - I hadn't had any instructions and I'd already been told I could sit by the bed for an hour morning and evening.' He was quite decent about it - he said 'Don't let it happen again - I'll give you the instructions.' I'd thought I was in for a real dressing down, but he didn't treat me too badly." Mr. Mears's submissive attitude might possibly connect in his case with the many years he had spent in the navy, but his approach of expecting the hospital to have authority over his every action was the general attitude of most of the patients. Some of those who suspected that they were doing more than they were allowed said that they understated their activity when talking to the doctors "because I didn't want to get the nurses into trouble." Thus the hospital which hoped that it spoke with one voice was seen to be divided, with, in this case, the nurses being in a position of vulnerability comparable to the status the patients themselves had.

When anticipating their discharge from hospital, only three patients spoke of unqualified impatience to get home. Some were impatient but "afraid of being an invalid at home" or felt that "here is the best place." Of those who spoke about this spontaneously, the majority took pains not to imply that they were impatient as that might precipitate their discharge too early. This feeling was usually linked with the desire to be reassured that they were really all right before they went - if the decision was made by the doctors without their own influence, then it could be taken to be a statement that they were all right - and also with the fear that was present in most people's minds about a recurrence. Mr. Oliver summarised many people's feelings with the words "It's better to stop here and to be put right and not have to come back in again."

This section on the hospital as an aspect of the patient's role-set has shown that it had a position which the patient saw as primary to his situation. The things which were most crucial to him at that time, his life, his health and the kind of future that he was to have, were all being controlled for him and he submitted to this authority with dependence. Where he thought he was not being told enough, he tried to make the system work for him by treating actions as though they were words. Yet the messages that he received were contradictory and gave him less help than they were meant to. Considering the hospital as an agent of socialisation into his convalescent and future life, one must return to the point discussed in the previous chapter as to whether the hospital really believes that it should fulfill this function. For as long as the hospital is confused about this, so long will the patient receive contradictory messages. The sum of these messages, which continues with him into his recovery at home concerns how he is to understand his position along the continuum of illness/health and how he is to understand what behaviour is appropriate to that position.

b) The Wives.

Although this section is being presented as the wife's perception of her husband's situation, and the activity that she foresees in promoting his conformity to her model of convalescence, it is necessary to remember

that she was herself being influenced in this perception. The predominant influence for the present purpose is that of her immediate family, which in every case was her children. Each family, even when the children were no longer living at home, had a pre-illness pattern of close and regular communication. In the few instances where the married children were not living near their parents, (often within walking distance), regular visiting and telephone communication ^{were} already the established pattern. While this could be considered surprising in a city like Coventry, which is commonly thought to have a more-than-average transitional population, no significance can be claimed for it in a sample of this size. It is worth noting, however, that both the Coventry-born marital pairs, and those who had previously migrated to Coventry and settled, had close family members in contact with them.

b.1) The wives in relation to their families.

For some wives, especially those who had young, or school age children at home, there were extra stresses in addition to the illness because of conflict between their roles as wife and mother, which until that time they had managed without undue strain. Now their time and energy had to be divided between their wish to be with their husband, and the need to keep the home functioning with some semblance of normality for the sake of the children; meals had to be cooked, laundry done etc. Not only did this constitute a physical strain, but they had to offer support and reassurance to the children who were upset by their father's sudden departure.

"Well, you've got everything really. You try to keep yourself smart to go up to the hospital....and then you've got the family and all their commitments, and then you've got visitors coming so you've got housework, and then there's food. You feel as if you've got everything - no single thing. It isn't as if when you come back you can sit down."

Mrs. Berry's children were distressed by the knowledge of their father's illness and although she was herself frightened that he would die, she tried to comfort them. They became difficult to manage, even though she claimed that she rather than her husband was the normal source of discipline.

"Naisy! - Devils! I had to leave them - I didn't know where they were.... That's why I couldn't go up at night time....I left them four hours during the day - though I would have loved to go back up at night, but I couldn't." The strain that she was under, and her fear that she might have to bring up two boys herself as a widow, she felt made her less able to be patient and caring towards them.

Mrs. Fraser, who had a five-year-old, "talked him round" to stop his fretting.

For these younger children their anxiety could only partly be relieved by their mother's reassurance, and it wasn't until their fathers were well enough to be visited by them at the hospital that they were really satisfied that he would be all right. In the meantime, the wives were having to console them, cope with the behaviour that resulted from their insecurity, and also hide their own worry and distress from them.

For the wives with adult children, the picture was very different. The children were a source of support and strength rather than a responsibility. Each family unit perceived the situation as a serious crisis, demanding a response which, at least in the early stages, over-rode their normal commitments. Married children living at some distance, took time off work to come home; those nearby either invited their mother to stay with them or moved into the parental home.

While 'help patterns' in crisis situations have been shown to operate in families with only occasional contacts (Sussman (1959), Sussman and Burchinall (1962)), these families were already in close contact. The situation had similarities to the Young and Willmott (1957) study, in which regular contact would develop quickly and smoothly into extensive help and support when the circumstances demanded it. All the wives experienced this help as supportive, although some refused help as a way of maintaining their independence. Mrs. Archer, who went to stay with her married son, spoke for many of the wives when she said "I would have had to cope if I had been on my own, but my son and daughter-in-law have been a great help." Apart from offering care and support, the tasks most frequently undertaken by the adult

children were driving their mother to and from the hospital, strenuous activities such as bringing a bed downstairs, and assuming some of the father's instrumental tasks which had a degree of urgency about them.

While each family with adult children established its own pattern of hospital visiting either having a rota, or going in groups, in almost all families the wife was the focal point for managing this and for disseminating information. She was, in effect, the pivot of the family unit, and the primary point of articulation between the family system and hospital system. The few exceptions to this would seem to reflect a particular interplay of relationships, for instance the family where the son had more confidence than his mother in seeking information from the hospital staff. In most families, however, the wife was acknowledged by all the parties concerned, i.e. the family, her husband, and the hospital, to be the primary articulator.

It is therefore within this context of the wife as a part of the family system that her experience of the crisis, her interaction with her husband and her prescriptions for him as a sick and later convalescent person need to be seen. Because her perception of the crisis colours both her interaction and her expectations of the future, this needs to be considered first.

b.2) The wives' views of the crisis.

The transition from health to illness and the behaviour that is seen to be appropriate as the progressive stages are reinterpreted (Mechanic (1961), Karl and Cobb (1966), Robinson (1971)) had a distinctive characteristic among the families that were interviewed. In all except two instances where the wife had previously been consciously concerned about his health - "I sensed something wasn't right with him" - the heart attack was seen as completely unexpected. In those instances where the attack occurred at home, some wives acted immediately in calling a doctor, whether or not they guessed at the diagnosis - "Something tells you its serious"; other were persuaded by their husbands to wait to see if the pain passed off. For these, the decision to take action was a combination of the length of time that the pain persisted, the severity of the pain that their husband was suffering, and the need to consider some more serious cause for the pain when the ineffectiveness of

home-remedies for indigestion called that diagnosis into question. This process of the early normalisation of symptoms within known and manageable classifications, giving way to a recognition of severe abnormality which needs expert management, is a direct parallel of the process within the families studies by Davis (1963), except that it was foreshortened into a time span of a few hours. One feature, however, that in retrospect most wives recognised, which is perhaps more characteristic of cardiac disease than of some other illnesses, is that there had been changes in their husbands over the preceding months which they had noticed but not attributed any significance to. Frequently mentioned changes were that he was more tired, more irritable or had frequent indigestion, for all of which some reasonable explanation could be found. Their confidence in their explanation of symptoms was even greater when the husband had been receiving medical treatment for some other condition; Mrs. Langton, for instance, believed his first episode of chest pain was a recurrence of his bronchitis for which he could repeat the treatment the doctor had previously prescribed.

For those wives whose husbands had the heart attack while they were at work, there was no process of decision making. The first they knew about it was a message from his work to say that he had been sent to the hospital.

While it is possible to hypothesise theoretically that even this abbreviated illness behaviour may foreshadow the subsequent pattern of the convalescent behaviour, the data cannot substantiate this as there are too many variables involved in such a small sample. To argue this assumes that there is some inherent consistency between illness behaviour during the passage into the sick role, the ways in which the sick role is acted out, and the convalescent passage back towards health. The investigation of the full sequence would be very valuable, and would need a research design which could sample from patients at a pre-diagnosis stage. While the present study is aware of the total time-span, it is important to note that the events leading up to the recognition of the crisis were only reported after the most acute phase had passed and that they had therefore already been re-interpreted in the light of later knowledge.

Although, therefore, there were variations in the point of time at which the wives identified the situation as a crisis, once they knew the diagnosis and their husband had become a hospital patient, every wife experienced her situation in terms of severe crisis. The freedom with which the wives verbalized their experience of the situation naturally varied. Many spoke openly of their fear that he was going to die, others inferred it in their relief that he was getting better. Others who gave no indication that they had had any thought that he might die (or who were defended against admitting it to themselves or to the researcher) spoke mostly about the major disruption to their established family routine - the accustomed ordering of their day and times when they would have carried out activities with and for their husband. Their sense of loss, both actual because he was not at home and the greater threatened loss if he were to die, coupled with the often extreme disorganization of their personal lives suggest a form of reaction very closely allied to that of the denial and acute grief stages of bereavement. (Lindemann (1944), Gorer (1965)). In their shock and bewilderment, they were both experiencing actual loss and anticipating even greater loss.

Although his admission to hospital formed the peak of the crisis for many wives, there was also often a sense of relief. The burdens of uncertainty about the right thing to do, and the helplessness of being unable to relieve the pain could be handed over to people who quickly demonstrated their competence over these worrying things. It was, therefore, at this very early stage that their confidence in 'the experts' became significant. The fact that this was such a universal experience seems to point to the satisfactory 'marriage' of the wives' need to believe in the hospital's competence, and the hospital's ability to demonstrate this. The willing submission to expert authority which marked this phase and was maintained throughout the critical period of the illness, resulted in many wives continuing to place very great importance on the hospital's view of their husbands' future progress. Although for some, a degree of disillusion set in later, accompanied by some anger, the basic orientation remained a positive

but submissive one.

b.5) The wives' interaction with their husbands.

When the wife visited her husband in the hospital, she was, as has been seen, bringing together his previous world, and his new world. Most of them visited at least once every day for prolonged periods. There is some tentative evidence that the ones who did not do so were finding that a previously strained relationship could not contain the increased strain. Relieved of the anxiety of nursing care, some wives saw their major role as enablers. In doing this they were both wanting to help him to tolerate the sick role - "keeping him happy", "stopping him fretting" and also reinforcing what they perceived to be the hospital's aims at any particular stage. In this way, not having an influential status of their own, they aligned themselves with the hospital's authoritative status as health, progress and activity definers.

While acting as chief representative of the 'outside world', they were very careful to monitor the kind of information that their husbands were allowed to have. In doing this, they were beginning to implement a 'mood-manager' role that frequently continued well into his convalescence. (It may be noted here that, later, 'activity-manager' is allied to this, but at this stage, the hospital was carrying out that function). There were two closely related aspects of 'mood-management', which concerned protectiveness and confidence-building. Some of their activities served both purposes. For instance, they went to great lengths to hide their stress and anxiety and to present themselves as coping and confident. Mrs. Langton, for instance, who felt physically ill as a result of the shock - "I really felt terrible.... but I did put a bright face on. I was absolutely determined that he wasn't going to see....and all this making more tension. I must appear (normal), and always make my face up, and I went into the cloakroom to make sure I looked all right....I was absolutely determined he shouldn't worry about me - absolutely determined. I managed to! I was very proud of myself." This form of presentation served both to insulate the husband from concern about the outside world, and to boost his morale by normalising the situation - she

wasn't worried, because there was nothing to worry about.* Confidence-building also took the form of reassuring him about his progress and her ways of recognising that he was improving. Protective activities took the form of withholding anxious-making information, such as the accident of a favourite grandchild and attempts to space out the flow of visitors so that he did not become over-tired.

In ways such as these, much of the interaction between the husband and wife can be seen to be characterised by artificiality as a way of handling the stress. The wife, having been relieved of the primary caring role, devoted herself to reinforcing and collaborating with those who were performing it.

There was considerable variation between the husbands as to whether they saw through this artificiality. Some knew that their wives were worried in spite of their attempts to hide it, and were content to allow a mutual facade to continue. Others were less clear about the messages they were meant to pick up. "I don't think she was a bit worried at all - I was rather surprised" was the comment of one man, whose wife had gone to considerable lengths to force herself to look as though she was all right. Another wife whose attempts to impose normality on the situation continued into the convalescent period, confused her husband by teasing him about staying in hospital longer than was necessary. Mr. Easton, who believed while he was in hospital that his wife was giving him a full picture of the situation at home, realised afterwards that he had had little realisation of the extent of the family's upheaval, but far from feeling that the pretence had been deceitful, he saw it as positive "So you (his wife) were doing a back-up job by coming with a smiling face and saying 'We are coping'". Although not resented, the constraints on free communication which were used at this time, often established a pattern for the future in which discussion of anxiety became a taboo - a type of game (Barne (1964)) in which the other person's level of anxiety could be manipulated by what was and was not expressed Footnote. This may be considered a parallel to the mutual pretence context of Glaser and Strauss (1965).

b.4) The wives' expectations of the future.

The themes which unite the hospital and post-hospital periods in the wives' views concerned the sense of threat to their husbands' lives and the related need to promote his conformity to approved behaviour in order to ensure his survival. In looking ahead to the time when the hospital would terminate its day-to-day function as health and progress definer, and activity controller, all the wives predicted that their own role would become more significant. It was as though they assumed that some if not all parts of the hospital's functions would devolve onto them - they would inherit, with the appropriate qualms, the mantle of the prophet. Although the differences within these presumed roles need to be examined, the fact that this assumption was so universal (in some form or other) is very interesting. It may tentatively be viewed as throwing new doubt on Parsons and Fox's (1952) contention that the nuclear family is unsuited to the performance of these functions.

While all wives were convinced of the importance of the role that they would have to play, there was considerable uncertainty for many of them as to how it should be defined. Some wives looked to the hospital for a prescription for their roles. When they felt that this was not provided, or that it was too vague to enable them to implement it, they had to construct their image of the role from other sources. These sources were usually :- the common wisdom about how wives should behave towards sick husbands, role models provided by people they knew who had been in comparable circumstances, and their perceptions of the ideal-type of role that they thought the hospital had, or should have been playing. Their personal recipe drew in different measures on these ingredients and was determined largely by what they thought would be possible in the light of their own family pattern.

Another universally held notion was that to a greater or lesser extent and in general or specific ways, there would be changes in the future. Over some specific tasks, which were among the most strenuous activities that their husbands undertook, they were completely convinced that there would be changes. Decorating was one such most frequently itemised, and some wives

were adamant that their husband's would not do this in future; either they would do it themselves or they would pay to have it done professionally. Such aspects of restricted activity were being foreseen in the immediate post-crisis period at a time when their husbands' capacity for future exertion was still not known. While having difficulty in conceptualising changes that they felt to be intangible, they were, perhaps, implying through the concrete items their attitude and expectation about the less tangible aspects. While this was very real to them in attempting to forecast future changes which they saw themselves as having a major part in implementing, the actual changes which lasted for more than a brief period were less extensive than they had predicted. This seems to imply that they had a tendency to underestimate their husbands' future capacity - and perhaps conversely to overestimate the extent to which they would take over their tasks.

A third common theme as they predicted their future, was that they foresaw difficulties. There seem to be several interesting features to consider in this expectation of difficulty. Firstly, the fact that it was so universal means that it referred to something beyond the individual pattern and circumstances of each family unit. Secondly, that, at one and the same time, the wives seemed to have a great deal of certainty about the vital importance of their role, but a great deal of uncertainty about executing it. Thirdly, that the changes would have to be acted out within the known and established setting, with all its connotations of normality.

Understandably, the wives expressed these anxieties in terms which related to their immediate situations. It is useful, though, to differentiate between those who saw the difficulties as arising primarily from their husband's personality, their pattern of relating and established way of life, and those who expressed some measure of dissatisfaction with their past mode of life and hoped that the disruption that had been created by the illness might serve to bring about changes that they had wanted for a long time.

For the first of these groups, the changes were in the nature of a threat which had to be tolerated because of the acute danger to his health. Mrs. Fraser, for instance, had maintained family harmony by keeping things

running smoothly but had stayed in the background and made few demands on her husband for companionship. When not at work, he had been out at the club, the pub, fishing or playing with the child in the park. She described him as an impatient explosive person who could never sit still and "if he is in the house, he paces around." The prospect of his being at home all day on very restricted activity seemed formidable. In similar vein, Mrs. Keoghan said "I'm going to have an awful job keeping him tied down....He gets very irritable and he's got to be up doing something." In considering the difficulties in instituting changes, the wives frequently related them to the established ways by which her husband found satisfying occupation and/or their pre-existing relationship. For those wives who had allowed and perhaps encouraged their husbands to be dependant on them the foreseen changes took the form of an extension of the same trend. Mrs. Hewitt said "I've always taken a lot of responsibility in the home, more than my husband - he's never made the decisions. He'd never make a decision on his own - we make them together. But he's always guided by me - he says 'Oh, you went to a better school than I did, I'll leave it to you'". When she was asked about how this would work out when he was discharged, she said "Yes, I think he will depend on me. He's not an easy person to persuade to do things - he's a bit stubborn. But I think the fact that he has been so ill and had such a shock - he'll be a bit easier to manage." The significance of this comment is not only in the further development of an established pattern, but in the efficiency of the crisis for implementing change.

One oft-repeated prediction of difficulty concerned the wives' responsibility to carry out the dietary instructions that they expected their husbands to bring back from the hospital. Mrs. Neale said "I don't know how I will cope with his diet - it's going to be a problem. He has always like/his food - steamed puddings and things he shouldn't have - and I've made them for him. It will seem queer not doing this kind of cooking any more." Mrs. Keoghan said "He's not an enormous eater, but he's got a very sweet tooth." Mrs. Irwin, whose husband had had quite a lot of ill-health had tried to keep him happy - "He likes his comfortable chair and a comfortable

bed, and lots of food - he isn't going to like the diet." Many of them talked about this topic as though they believed that there is a symbolic significance to food and that by providing the meals that their husbands enjoyed they were doing more than nourishing his body. There seems to be two interesting aspects to this: that highly specific instructions over which they could exercise almost complete control but were in an emotionally significant area seemed to them to be more problematic than did less specific instructions in a sphere of little significance e.g. whether he should mow the lawn; also that their view tends to confirm other research data (e.g. Twaddle (1969)) which suggested dietary restrictions were one of the least acceptable aspects of a medical regime.

The second group of wives, who foresaw the changes in a more positive light as a way of achieving a desired goal, shared with the previous group the dual orientation of viewing the present and future in the context of the past, and also as seeing the crisis as a change-promoting agent. For some this was fairly low-key - Mrs. Jessop had been lonely all day since she retired from work and had enjoyed the period of the three-day week when her husband had been at home more. The prospect of his convalescence was welcome to her as he would be around the house. For others, their husband now agreed to change in their life-style - for Mrs. Oliver, her warnings about the amount of overtime he had been doing were now taken note of - for Mrs. Easton, he would slow down and stop rushing around so much. The most far-reaching changes were hoped for by others who looked for some radical alteration in the way that their husband interacted within the family. In the Mears family, there had been a great deal of strain within the marriage for many years, and they had little communication about anything, far less the distress they had both experienced about the death of two of their children many years before. He had taken to going out every evening and drinking very heavily, didn't eat a balanced diet and was extremely tense. She gave up trying to influence him and went her own way - "I just couldn't tell him any more. I used to pray that something would happen that would tell him - nothing drastic"...."He's definitely been taught a lesson - he's

eating the right food now; everything I've told him to have....If he'd done as I told him he wouldn't be like this." Her hope was that this long-standing difficulty would come to a head because of the illness and that there would be changes in their relationship as well as in some of his behaviour. The Berry family had also had long term strain, from which he escaped by spending all his time at the pub. Mrs. Berry had a personal investment in wanting him to observe the restrictions of convalescence as he would be at home more, but later events showed that the vigour of her attempts to manage him in effect drove him out again. For her the desired changes did not materialise.

In addition to the influence of the past on the kind of change that was predicted for the future, many wives used their own past experience of illness as guidelines for their husbands' behaviour. Two thirds of the wives had had personal experience of acute illness, and for many of them this had included a period of hospitalisation. There were several ways in which this influenced their perception of their husbands' situations and his future. For Mrs. Hewitt, it gave her confidence - "I'm not strange to hospital - I'm not the type that panics about hospital treatment....You've seen so many things and you know that they can do - it gives you faith when you have had a bit of it yourself,.....So that possibly somebody who had never been to hospital might have been very very frightened, it didn't frighten me so much - you put yourself in their hands and this has made my husband a bit more appreciative of what goes on. He visited me in hospital and knows what they can do - he's put himself in their hands and let them do what they want to." Part of her confidence was not so much in familiarity with hospitals as such, but the trust that she had developed in doctors - the idea that if you do as you are told everything will be all right. The theme of the need to carry out medical instructions recurred regularly. Sometimes it was phrased in such a way as to indicate that it helped them understand their husbands' difficulties - Mrs. Archer said "It has been hard for me to learn to adjust - in all probability he will find it hard too." Mrs. Mears said "...such a strange feeling coming out - you feel as if you are on your

own - you've had all the medical people round you and they're there if you have any little tiny pain - and then you are on your own. I think he might start to think (Oh, am I all right?'. Sometimes I think he won't be like that, he's too tough and then I wonder if he will be." Sometimes alongside this empathy and, on occasions, as the more predominant expression was the feeling that they had managed to abide by the rules, and so they expected him to be able to do it too. In connection with stopping smoking, Mrs. Dodds said "I think well I could do it, why can't he. I packed up four years ago after pneumonia." Their own achievement in recovering from illness seemed to set a standard to which they now expected their husbands to conform. The use of this experienced-based model continued throughout much of the convalescent period, the only modification to it being a tendency for criticism to outweigh empathy in situations where the husband was not fulfilling the wife's expectations.

b.5) The wives' prescriptions for their own role.

These influences from the past and the specific nature of the crisis, with all the sense of threat that it implied, affected both the wives' perception of the convalescent status and their own role in relation to it. There were two main ways in which this was seen. Some wives considered that their husbands would take the major responsibility for determining their own path, with themselves acting as a kind of safety-net if he seemed to them to get it wrong. Others saw themselves more actively determining the path as though the major responsibility was their own.

The first group professed to be able to rely on their husbands' "sense". "I think he's pretty sensible - I think he'll do what the doctors say. He's like that, he'll do what he is told." Mrs. Keoghan said "He's sensible man and rather than worry anybody I think he'll do as he's told." But Mrs. Neale realised that his 'sense' might not be the whole answer - "In my own mind I think if he takes it easy he'll be all right. Of course we shall have to watch him and see that he doesn't do things as he shouldn't. It won't be easy, but he's wise and will watch it himself. He wouldn't let me worry over anything - I shall try not to, but I shall be quite firm and tell him

that he hasn't got to do it." The message of this apparently being that he would be seen to be making his own decisions about his activities unless she disagreed with them, in which case she would become the final arbiter. When it was seen as primarily a joint responsibility - "We shall carry out the advice that is given to us by people who know better than we do" - Mrs. Langton still had her own particular perspective which was very dependent on receiving a medical model - "I don't want him to smoke - I don't want him to do anything the doctor says is wrong in any way. I want to do everything right." Thus the dilemma of leaving the prime responsibility to the husband came if his interpretation of his convalescence turned out to be different from her own.

The second group of wives saw themselves as the major definers of the convalescent process. While many of these hoped for a clear role prescription from the hospital, they had considerable certainty about their own activity. Their activities were not necessarily going to be fully overt and in some ways they differed from the group just discussed only in the extent of their assumed responsibility. The main activities that they predicted that they would undertake can be classified as:-

Enforcer of medical recommendations. In doing this, they were allying themselves very closely with the authority of the doctors and the hospital, with the feeling that they would assume the hospital's functions, especially the disciplining aspects of it. "After he leaves the hospital, then I'll take over"

Manager of activities. The wives saw themselves as ultimate arbiter as to what activities he might undertake. Some things they would forbid, others they would contrive to manipulate - such as Mrs. Keeghan's decision to buy an electric lawn mower in order to evade a confrontation over her decision that her husband must not use the heavy push-mower again.

Manager of mood. This was a more subtle form of manipulation in which they considered that they knew how to modify his attitudes and feelings, with the result that if these were 'right' he would be more amenable to their influence over his activities. Mrs. Dodds said "I've learnt I can't do anything with

nagging; I've just got to do it gently. It's no good getting nasty with him - not to get him to do anything. I've got to go round the corner to get him to do anything....I just gently get him round till I get him in a good mood and just say 'Right, that's it'....I can do more like that than if I go mad at him. I have to bully him out of depression and all that. To get him to do anything I've just got to gently steer him round to it. He comes round eventually....I've got to be a bit careful." She had learnt this method of managing him during an earlier illness when she had discovered "that he is inclined to be a little bit sorry for himself." Similarly, Mrs. Oliver's husband had got depressed after a previous illness "He's full of self pity. You have to be firm with him....It's up to me. I'm going to have a rough time. I'll have to be firm - it's for his own good. I'll get him talked round."

Protector. Both 'mood-manager' and this final category were aspects of the wives' functions that they were able to carry out while their husbands were in hospital and which they expected to continue. The protector activity was to ensure that no undue demands were made on him by others - the number of visitors and the length of time that they stayed would be monitored. He was to be protected from situations which would make him anxious or over-excite him. This is a direct continuation of her function as chief link between him while he was within the hospital system and the other social systems with which she was still interacting.

The importance of the role which they foresaw for themselves, is highlighted by the plans made by those wives who were working to have a trusted substitute to carry out their functions while they could not be in the house. The fear that they were experiencing was "whether he would be sensible at home and not try to do too much" when she wasn't there. The substitute was almost always one of the family. Mrs. Keoghan said "I've thought about this - I've had plenty of time to think - When I'm out in the mornings, if he's home next week....the youngest daughter still has another week (of holiday)....she'll keep an eye on dad for that week." Mrs. Hewitt hoped that the help she would get would make it possible for her to go back to work -

"Well at first I'll have some time off. Though they (employers) are very good you can't expect them to keep the job open indefinitely - if he's going to be off a long time, naturally I'll have to think about that because I get good money and jobs are hard to come by. My daughter-in-law is very good and her mother is very good and I think they'd be prepared to share the time and come up and spend a few hours with him. I can come home lunch time - having the car." Mrs. Oliver hoped to get her neighbour to "keep an eye on him" as her family were not so available. Mrs. Mears' daughter said that her mother was not working "because she wants to be at home when he leaves hospital to look after him and see he eats all right - Then she'll go back to work when she knows he's all right and is on the mend." Mrs. Mears was one of the wives who hoped for a fundamental change-for-the-better in family functioning as a result of his illness and her action in offering care to him was, in part at least, symbolic of the new pattern that she hoped for. Two of these working wives while making these short-term plans, also considered the possibility that they might change their jobs to another which would enable them to spend more time at home because the hours would be shorter. Later events showed that both did eventually do this, though Mrs. Mears left her job without finding new employment and implied some uncertainty as to whether she would do so.

In summarising this long section on the wives as a unit of the patients' role-set in which their own view of the situation has been set out, it was recognised first that they continued to be members of their family systems and that this either increased their stress or offered support. They were the main source of contact between their husbands within the hospital and his outside life. Their views of the crisis have been seen to relate to their attitudes to the hospital, and this in its turn influenced the ways that they interacted with their husbands. This interaction was characterised by encouragement and protection, both spheres that the hospital had not taken over from them, and also by an inhibition of the open acknowledgement of anxiety. Their behaviour during the convalescent period will be seen to be largely a continuation of these patterns, although then complicated by the

addition of some of the tasks that the hospital was now fulfilling. Their views of the future were shown to predict extensive changes, which were usually viewed as problematic, although sometimes the prospect of change was welcomed. During his time in hospital, they had considerable confidence about the roles that they would play in relation to their husbands once they were convalescing. However, chapter 6 will indicate that they found that prediction was easier than performance.

o) The 'cardiac wise'.

The discovery of the significance of other patients with heart conditions was unexpected and came from the analysis of the transcriptions of the interviews. At the time the interviews were taking place, I had not fully recognised the purpose of these anecdotes, which had been tolerated as digressions to which I would listen patiently before trying to get back to the respondents own experience. My ideas about the significance of these references grew from questioning firstly why they were a recurring feature of the interviews, and then from studying the kinds of things that the respondents said about other cardiac patients.

As has been indicated in the previous chapter, most studies of hospital patients forming their own systems and subcultures are based on long-stay hospitals in which the 'senior' patients transmit the culture to the new admissions. - e.g. studies on King (1968 p.340-345) and Beth (1963). The fact that something comparable happened among patients in a short-stay setting with the characteristics frequent moves that have already been described, is very interesting. While no final conclusions can be drawn, the evidence seems to suggest that the conditions promoting the development of this culture may have been the shared experience of crisis and resulting threat and also the desire on the part of the first-time patients to find models. 'Seniority' in this context was not established by length of stay, as none stayed for long, but by having had one or more previous heart attacks. These old-timers were regarded as knowledgeable and valued models, even though they confirmed the fears of the first-time patients that the heart attack could be repeated. It is this sense that the term 'cardiac culture'

is being used.

c.1) 'Wise' impatient.

The other heart patients, firstly, were a source of comfort that he was not alone in his trouble. Mr. Gould was relieved when another patient admitted that he was afraid and yet could behave with courage "We were both frightened and we were drawn together and got courage from one another." Other patients also had chest pain, which, as has already been discussed was not adequately explained by the staff, so they found reassurance from each other. Mr. Langton - "I'm given to understand by one or two patients I have talked to that it's normal procedure," and Mr. Dedds - "You can turn to someone else and he's got a pain in his chest and I've got a pain in my chest and so what." Mr. Jessop who had a great deal of insight into his own behaviour, said "I imagined the pains had come back the night I was on my own, but I haven't imagined any more pains since I've been with other people." Mr. Keoghan, although he maintained that he was not afraid of dying, spoke of losing his fear of death by seeing how peacefully two other patients in the ward had died. For Mr. Fraser, though, the death of another patient was very upsetting and reinforced his will to live; his narrative about the death ended with "I'm no baby - I don't fear many things, but life is the most precious thing - it's the only one I've got and I don't want to lose it."

The sense of fraternity among the cardiac patients extended not only onto the other wards, but also sometimes took in their future plans. Three patients who thought that they might have to change their jobs were offered jobs by fellow patients who were in a position in their own firms to be able to influence appointments. This gesture was warmly appreciated at the time and was accepted as a genuine offer, but it is interesting to note that for two of them (the third withdrew from the sample) nothing further came of it. It was as if the crisis precipitated the offer and its acceptance, but later both parties saw it as inappropriate. Several patients, however, kept in touch for a considerable period after their discharges and seemed to find this contact meaningful.

The uses which the respondents seemed to make of the cardiac culture directly parallel the functions that the hospital system served, or at least that they wanted it to serve; namely, making understandable their health and progress and providing a model for their future. Over the first of these, it would be useful to have more extensive data on the kind of medical information that was shared among the patients, especially in the C.C.U. My observations from spending a considerable amount of time on the ward indicate that they discussed the details of their medical conditions quite fully and certainly some of the respondents seemed to think that they knew a great deal about the particular features of their fellow-patients' illnesses. But, in view of the very confused and distorted information which some of the respondents had about their own conditions, it must be doubted whether this sharing was really as profitable as the patients seemed to feel that it was. In addition to the exchange of information, patients charted their expectations for their own progress from observing the stages of progress of the others. They were, in fact, doing in a very condensed time span, what Beth's (op.cit.) patients were doing over a much longer time period. For some, this became competitive. Mr. Jessep described himself and two others who had been admitted at about the same time as "being in a horse race." For others, the comparison of their treatment with that of others served to define how serious the heart attack had been - Mr. Harten "Judging from the length of time the average person was in the C.C.U. and on the machine and the treatment and tablets they had, I had more. Most - the average was on the monitor for 3 days; I was on for 8 days. I was blood tested every morning where the others had a blood test the first morning they were in and then may have had another one. Not everyone went on that drip - perhaps less than fifty per cent had that. So in my own mind, judging it from that, I think it was fairly serious. A fairly good one." While this retrospective evaluation had some errors of fact, it was a clear presentation of the ways in which he used other people to define his own health state. One which, interestingly, agrees with the medical classification of his heart attack as having been a serious one.

In their search for a model for their future life, the other patients were seen as providing both positive and negative models. The influence of other heart patients will be seen to be of greater significance during the convalescent stage, but the pattern of using them as a reference group began during the period in hospital. At this stage the ones who were viewed as positive models to be identified with were the ones who seemed confident that life could go on. These were often patients who had had previous attacks and whose authority was respected. Mr. Keoghan - "That chap over there, he had one about three years ago and he says that the first six weeks are the worst - so long as you don't let it get you down." In addition to the patients with whom they were surrounded, many respondents talked of others they had known who had coped with life after a heart attack. Mr. Dodds's father had found a satisfactory *modus vivendi*; others knew people at work. These, and their fellow patients were all serving the purpose of reassuring them that their future life would be possible.

The negative models were seen as people who seemed to be holding to either extreme of the range of possible ways of coping. They were either rejecting or ignoring medical treatment. Mr. Fraser was critical of a patient who took his own discharge; Mr. Berry and Mr. Oliver both recounted stories about patients who had had to be readmitted soon after their heart attack "because they had over-done it at the beginning." At the other end of the scale were those patients who seemed to be overtly depressed and to have resigned themselves to a state of permanent invalidity. Mr. Dodds, who later found that much of his own life was shaped by his concern about his heart, spoke of a fellow patient whom he was trying to persuade that "having a heart attack isn't the end of everything."

Each individual's search for his own path through the cardiac-convalescent period was thus being influenced from the start by the experiences and attitudes of those around him. He learnt that just as patients were deemed to be good or bad patients, so there were expectations about the behaviour of the recovering cardiac. Almost all were definite that they were going to 'get it right', and the path that they would take seemed clearer to them during

this early stage than it did later.

c.2) 'Wise' visitors.

Once the patients were well enough to receive more visitors, they became increasingly open to the influence of those of their relatives and friends who had had heart trouble and who behaved and were behaved towards as 'the wise'. Although in all essentials the respondents wanted the same things from them as they wanted from their fellow cardiac patients, these visitors introduced a complicating factor in that they often represented an out-of-date or in some other way different orientation towards treatment and after-care. Their advice frequently contained the same contradictions as the patients felt that they were receiving from within the hospital - both reassurance and an even more cautious approach towards activity than the hospital seemed to be indicating. For instance Mr. Gould's sister, who had had a heart attack some years previously, came to visit him - "She meant well, but she gave me more concern than I'd had all week telling me what I should do and shouldn't do." She also questioned him about his tablets and his diet and contrasted them with her own treatment. Mr. Dodds, on the other hand, found his visitors more reassuring. He held a senior position in his firm, and many of his colleagues had had heart attacks. Their approach was that "he had joined the club" - in which the prevailing spirit was "whatever the doctor says to do, do."

d) 'Others'.

For the purpose of the present analysis of the patients' role-sets, 'others' is being used to include both non-cardiac inpatients and other visitors who did not have the special experience of heart conditions that the 'wise' possessed.

The 'other' patients, having a variety of medical conditions, introduced a new dimension into the respondents attempts to evaluate their own position. Some were surprised that the other patients seemed to be so ill - as though they had assumed until then that serious illness was equated only with heart conditions. Others were distressed by the helplessness of patients, for instance after a stroke, and saw in a new light both the extent of their

capacities and their limitations which frustrated their desire to offer help. When other patients appeared outwardly to be fairly well and were allowed to be active, Mr. Keoghan found himself trying to do as much as they did - because outwardly he looked well also. Mr. Langton who was more reluctant to increase his activity allowed the other patients to restrict him - "I felt I could walk to the toilet without the aid of anything, I was immediately shouted down in the ward here - that I just mustn't do it - even that short distance." In this situation the respondents could not be protected from distressing or demanding situations as they had been earlier, and as their wives tried to ensure that they should continue to be. Mrs. Archer, for instance, asked the Ward Sister if her husband could be moved into another part of the ward away from a blind young man whose condition was distressing him. Mr. Gould talked of his apprehension that a complaining patient might be moved into his section of the ward, as "he's getting on my nerves and I said 'If he moves in here, I'm afraid I shall have another heart attack'."

Not only did the 'other' patients widen the horizon against which the respondents saw themselves, but at the same time, the increasing flow of visitors introduced greater diversity. As representatives of his pre-illness life, they reminded him of other aspects of his life, his relationship to which during his period of convalescence, would have to be worked out.

II. The Crisis - As Experienced by the Patients.

Having reviewed the units of the role-set which both intentionally and unintentionally influenced the patients, it is important now to turn to see how the patients themselves described their experiences. This section, which will largely be quotations from their own words, assumes the interaction with the role-set, without a constant repetition of the fact that it was influencing and being influenced by these perceptions. Three main aspects of their views will be considered; their perceptions of the illness and their progress, their expectations about the outcome of the crisis, and their views of their wives' situations and role.

a) Their perceptions of the illness and their progress.

Most of the men believed themselves to have been in excellent health up to the time of the onset of the severe chest pain that marked their heart attack. Those who, with hindsight, remembered that they had been having pain or what they believed to be indigestion, had not seen this as demanding any redefinition of their health status. These symptoms had either been ignored, rationalised or treated with home remedies. The words that recur in most of the first interviews were "It's been a terrible shock", "A big shock", "So unexpected - I was so well - it came out of the blue", "It's been a big blow" and "A shock to realise I've been so seriously ill." Almost all the men and many of their wives also, said that they thought about it happening to other people but had never thought it might happen to them. Thus they found themselves precipitated into an unwelcome revision of their self-image - as someone to whom it could and had happened. Some cried with the pain or the shock of hearing the diagnosis and many were very frightened. Mr. Oliver - "I was frightened - anyone who says they're not frightened is telling a lie." This disruption of their established view of themselves was particularly acute in the early stages, but for many its effects were still noticeable many months later.

An aspect of this to which many referred and which had continuing implications was their revised view of the age-group to which they belonged. Mr. Easton who was aged 46 said "I think at times I've felt I've been doing too much. You still think you can throw ladders around and paint the front of the house as if you were 25." Mr. Archer, the eldest in the sample, said he felt useless because he could no longer continue to carry heavy sacks of potatoes for the shop - in doing which he had been proving how young he was for his age. Some others were shaken because in Mr. Neale's words (he was aged 63) "I used to think it was only old people get this condition" - he was reluctant to consider himself as even approaching this age-classification.

The four men who had had previous experience of being in hospital spoke with the same vividness about the shock of the present illness as did those without this experience, even though for them the sick-status was not so

completely foreign. Mr. Dodds tried to persuade himself that the successful cure of his previous illness gave him more confidence in this one, although he remained one of the most anxious men in the sample.

There was one patient with a totally different approach to the onset of his illness. The circumstances were rather unusual and therefore need to be outlined briefly in order to understand his reaction. Two of Mr. Mears's children had died one of leukemia and the other of 'muscular dystrophy' (the term he used). He had never resolved his grief process and had bottled his feelings inside himself, becoming increasingly estranged from his wife, with whom he hardly communicated. He had adopted a pattern of going out drinking every night - both to get out of the house and to drown his sorrows. During this period, which lasted several years, he had recurring chest pains, which he believed to be neuralgia, the lasting effects of an attack of shingles. His nerves "were in a shocking state" - an observation which was confirmed by his wife. He saw the illness as "the climax" of his life problems - "I've got this illness, and I know it's very serious. But I also knew that I would have it somehow. I knew eventually I would have it." "The treatment and the rest - the finest thing that has happened to me, although I knew full well that it was chasing me - is that I've had a heart attack. I knew it was chasing me and it had got to happen. I think that it is the finest thing that has happened to me, because life for me was unbearable. I'm better than I was - better mentally." "I feel better now than I've felt for about 6 years. My body feels more real - more relaxed. Like when you've been out and had a good game of football....for 6 years I've always had the feeling - what's round the corner?" "I feel very well - better than before. I think this thing is like a boil - come to a head, and that's it - finished. It has definitely given me a lot of consolation because this thing has been hanging over me all these years....This might be the climax and might help me in the future - I might not have any more." These extensive quotations which span several interviews, have been included to show how he was trying to work out in his own mind some understanding how the illness related to his established life pattern. While feeling that this illness "Was my own fault - not living right",

he was able to make use of the situation that he found himself in. During the research interviews he talked and wept about his distress in a way that he said he had never been able to do before. Once he had begun to be able to put his feelings into words, not only did he feel less tense in himself, but also his communication with his wife improved. She commented to me soon after his discharge "If he'd spoke before like he has to you, it wouldn't have been so hard for him....I think he's a lot better because he's opened up."

The use of the term crisis in Mr. Mears's situation introduces a different aspect of the definition of the term from the subjective experience of shock and threat of which the other patients spoke. It highlights the "period of disequilibrium" (Parad and Caplan (1960)) aspect of crisis which can promote change and results in a new pattern of handling stressful events. Mr. Mears had a fairly extreme level of dissatisfaction with his previous life style and the event of the illness precipitated a change which he had wanted but previously seemed to be unable to implement. Other patients also saw various forms of positive benefit resulting from their illness, and this will be discussed under the heading of their expectations for the future.

It has been argued earlier that all the patients saw their illness and admission to hospital as a crisis. Some further elaboration of this new seems to be necessary as there were some interesting differences in their experiences. This requires the separation for the purposes of analysis of the medical and the perceived crisis. The medical crisis followed a pattern of unidentified onset, the event of the myocardial infarction, diagnosis and acute physical distress, disorganisation and later recovery with or without complications. Parad and Caplan (op.cit.) have depicted this sequence as:-

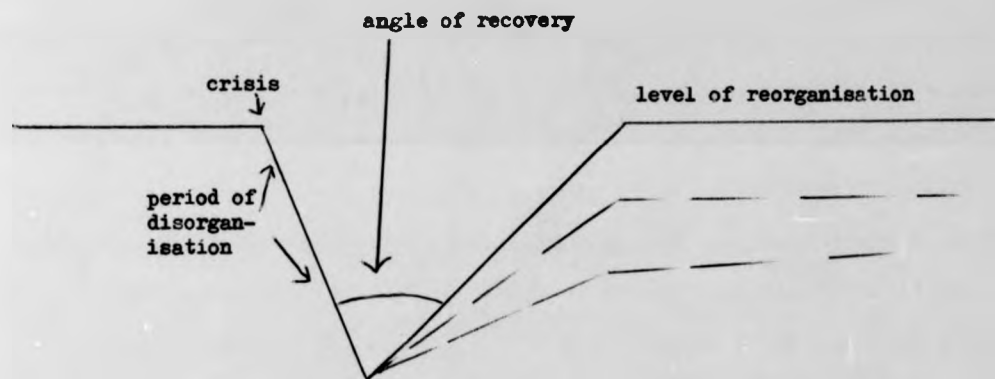


Diagram 2. Parad and Caplan's diagram of the sequence of a crisis.

The medical crisis can be seen to follow this pattern. The patients' perception of the situation as a crisis is an equally important aspect. Hill (in Waller and Hill (1951)) gives as one of the variables in making 'an event' into 'a crisis', "The definition the family makes....that is, whether members treat the event as if it were or as if it were not a threat to their status goals and objectives." The patients processes through Parad and Caplan's scheme followed the same path as the medical definition - crisis, disorganisation, recovery and reorganisation. The differences, however, can be seen at stage along the medical model that the subjective crisis-turning-point took place. For some, it was identical with the medical crisis. Others, perceived the crisis at the time that they were told the diagnosis. For others it came considerably later - at a time when the medical crisis was well on the way to resolution. The first of these (Group I) were patients such as Mr. Archer, Mr. Oliver and Mr. Langton who responded to the onset of symptoms with urgent action, recognising them as critical even if they did not know what it was that was wrong. The second time-scale (Group II) was illustrated by Mr. Neale and Mr. Jessop, who knew that the pain they had experienced was severe and indicated that something was wrong, but who didn't define it as critical until they had walked to the doctor's surgery and he had told them that they would have to be admitted to hospital immediately. Group III were patients who recognised that they were ill enough to need specialised treatment but did not experience the impact of this on them until later. This was Mr. Keogh's view of it after he had had a recurrence of pain during his recovery. "It's been a warning to me last night how serious it has been - I thought it was just something trivial."

This suggests that if the medical and perceived crisis were superimposed upon each other, these patterns would emerge:-

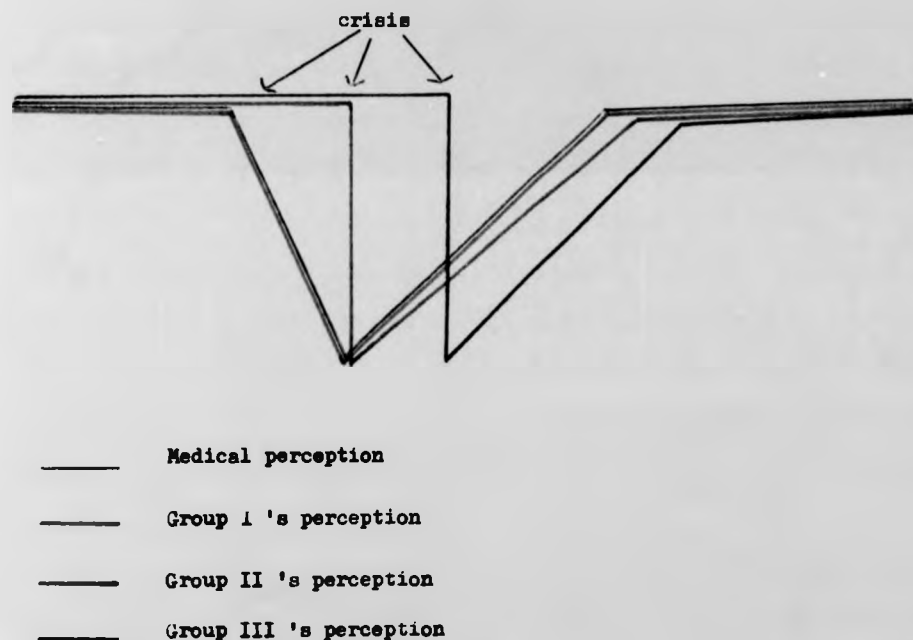


Diagram 3. Medical and patients' perceptions of crises related to each other.

This scheme could be elaborated further if the wives' perceptions of the onset of the crisis were to be differentiated from their husbands'. In most families there was consensus about their perception of the start of the state of crisis, or at least only a brief time-lag between the one defining crisis and the other agreeing. Even such minor discrepancies, however, serve to indicate the potential for dissonance which has been noted as an aspect of health behaviour (Vincent (1963)), but still needs considerably more study. The only instance of marked dissonance between husband and wife occurred within the stressed family situation of the Mears, which has already been described. His severe pain started on his way to work, so he returned home - "I went in....and said to my wife 'I'm having a coronary' 'Oh' she said 'You're silly - you've got indigestion' I said 'I'm having a coronary - send for the doctor'....My wife and daughter started laughing.... They thought I'd got indigestion and I was exaggerating." In order to humour him, his wife sent for the doctor, but as she did not indicate the symptoms were serious, it was some hours before he arrived. Her recognition of the crisis came "when the doctor had made his diagnosis and said he'd send for the ambulance....she started to cry then." One can hypothesise that if Mr. Mears had not had his personal motivation to be recognised as ill, he might have been persuaded to adopt his wife's definition of his symptoms as a non-crisis.

Many of the patients were concerned to know how serious their heart attack had been, and the devices that they used in their attempts to clarify this have already been discussed. Mr. Hewitt, whose only previous experience of illness was seeing his work-mates take days off when they had colds, said "This is how I reckon you are when you're ill - not having a cold." He was among the ones who said "I've been very ill" - a series of self-definitions which included patients who were medically classified into each of the Mild, Moderate and Severe groups, but which to each person individually was seen as 'severe'. Mr. Gould thought he had had a "minor attack", but was medically classified as Moderate. Those who thought that they had been very ill at first were pleased and relieved that they so quickly felt better. While still on

complete bed-rest many of them felt that they were cured and well enough to get up and do anything. In addition to the medical definition that they were improving, they often used subjective measures - "when I woke up this morning, I knew a change had taken place. All the pulsating had slowed right down. I knew I was going to make it." "I feel fine now, since the pain went." Some charted their improvement by interpreting their own actions; - "I knew I was better the day I felt hungry", "I'm better now, I didn't want to know anyone before", "I had a good night's sleep last night - it's a sign of recovery," also "It probably shows signs of progress, silly little things like when you started reading the papers and the book reading that you do." Several patients spoke of the change they noticed in themselves when they began to be able to enjoy having visitors.

The patients who felt after the first few days that ^{they} were "as fit as a fiddle" often had a nasty shock when they first got out of bed as they found how weak they were. It was as though they had taken the doctor's reassurance at face value and not as related to their stage of recovery, and this had been reinforced by their subjective feeling of being well while they made no exertion. The sensation of weakness after sitting in a chair or walking around their bed, was therefore unprepared for and introduced a new and unwelcome dimension to their view of their recovery. It was not surprising therefore that it was at this stage that several of the patients began to find it more difficult to say how well they were and how they were progressing. Both Mr. Irwin and Mr. Neale said with confidence that they were feeling very well a few days after their admission, but four days later felt "that it's difficult to know". When Mr. Jessop's rate of recovery slowed down and he had further pain he found "it's hard to believe I'm getting better."

It has already been suggested that the patients did not think that they had enough explanation of their episodes of pain. This point is again relevant here, as this symptom was a source of great confusion to them while they recovered. They had learnt at the onset of their illness that pain = danger. They now again had pain, which was similar though not as severe as the first time, and they felt it was disregarded. While staff attitudes

about this can only be inferred, it seems probable that the staff intended their low-key response to be reassuring. However, the actual result seemed to be that by the time the patients were discharged they did not know how to distinguish a serious pain from a not-serious one, they did not understand what brought the pain on nor were they confident about treating it themselves. These things will be seen to be of continuing concern to them during their convalescence at home.

b) Their expectations about the outcome of the crisis.

While the patients' comments about their present experience had a subjective reality about them, their views about the future tended to be far more speculative and were in a constant state of fluctuation. The most characteristic, and almost universal, aspect of their predictions was that they underestimated their future physical potential and conversely overestimated the amount of change that would occur. This was most noticeable in the first few days of their time in hospital, during which time several foresaw radical changes in their life-styles. Mr. Neale and Mr. Easton were among the men who thought they would change their jobs, but later found that they did not need to. Mr. Neale's job was "a pleasure to go to....Now I don't know how I shall be able to cope with it because I look after all the stores and there's a lot of heavy lifting." Mr. Easton - "I've been wondering about changing my job, to get something less demanding and I'd like more regular hours. Many people at my time of life want an opportunity for a change but can't make the break. Perhaps being ill and having it forced on me may be an advantage." Both had dropped this idea even before they left hospital. "It may have just been something I had thoughts of - I think probably as your health outlook alters....it's rather an exacting and demanding job" (Mr. Easton).

Several men commented on the ways that their illness had led them to re-evaluate their past lives and their sense of priorities. "Being in hospital, and what I've seen - it makes me think more". Several thought that they had been wasting their lives. Mr. Fraser - "These things run through my mind as I sit here - things that I haven't done that I should have done and

how much time I've wasted on being niggling and stupid." Mr. Gould - "I've worked every day of the week and where does it get us? - in here. When you think about it you know you could use the money, but when you get in here you realise you've wasted half your life." Although for some, such as those who had been working a lot of over-time, this re-evaluation related to their perceived cause of the heart attack, this was not always such a direct relationship. It seemed to have more to do with their feeling that they had been near the point of death and had been reprieved. This was so recent and so powerful a feeling, that what mattered to them was that if they were to have a future quantity of life, it should have a high quality. Seen in this way as an aspect of their state of crisis, their relinquishing of these new values as time passed becomes more intelligible. Several men found that the turmoil led them to reconsider their religious beliefs. While most of these returned to their previous attitudes, two men who described themselves as "a bad catholic" resumed regular church attendance. It may perhaps be significant that both of these men remained very anxious and were overtly concerned about the recurrence of the illness.

Although these early predictions of radical change were short-lived, all the men continued to be sure that some changes would take place. The ways that they discussed the future seemed to indicate that they were trying to resolve some of their own uncertainties about both their future health status and the kind of life that they would be able to lead. Those that expressed this in very general terms often seemed to be quite satisfied with vague statements at this stage. Mr. Jessop, Mr. Cook and Mr. Hewitt all used the phrase "I'm going to slow down in future"; Mr. Neale and Mr. Easton both thought that they would "do less." Mr. Langton and Mr. Gould both planned to ease the stress that they thought had contributed to the onset of the illness. Mr. Gould summed up for many men when he said "I can't go back into my old ways and try to do everything." On the whole, these general statements seemed to satisfy the patients during the early days of their time in hospital, although as their discharge drew nearer some realised that they were too vague to implement in everyday life. Those that were already

trying to foresee specific changes predicted that they would have to give up an activity that they thought was physically demanding. Many referred to decorating the house, others to their hobby - Mr. Jessop said "I'm a keen bowls player....I can't do it any more for a bit." Mr. Oliver said "Gardening - that's out. I'm a keen gardener."

While some of the patients saw these restrictions as lasting only for a period of time - such as Mr. Jessop's phrase just quoted "for a bit", many were extremely uncertain about any idea of progression because they did not know what their eventual health status would be. Any attempt, therefore, to categorise their future expectations into short-term and ultimate would do less than justice to the data. Indeed it would obscure the significant facts of their confusion about this very thing.

Instead of such a model for analysis, it is more useful to consider both the overall and the specific features of their predictions as falling at points along three intersecting continua. These are: Gain - Loss i.e. whether the change is seen as advantageous or disadvantageous; High Value - Low Value i.e. the amount of personal investment in the activity; and High Threat - Low Threat i.e. the perceived risk that is involved. These are shown diagrammatically as:-

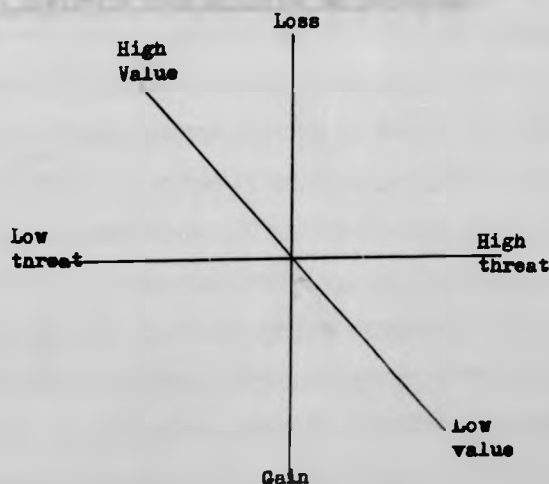


Diagram 4. Predicted activity analysed on model of Gain - Value - Threat.

- 101 -

For some of the predictions, a coherent pattern can be seen. Thus Mr. Oliver, who valued his gardening highly, saw, giving it up as a loss, which was necessary because it seemed to hold a high threat. His expectation was therefore:-

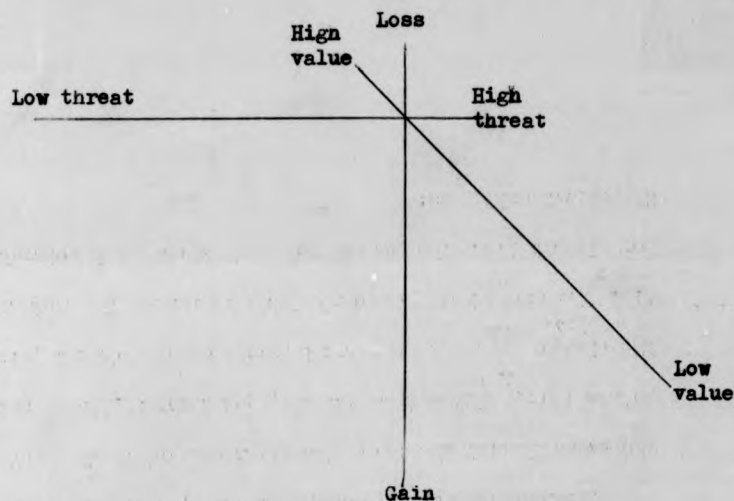


Diagram 5. Mr. Oliver's view of giving up gardening.

But for Mr. Archer, gardening was of little interest, of high threat and he was neutral about stopping doing it. For him the intersection came at a different point:-

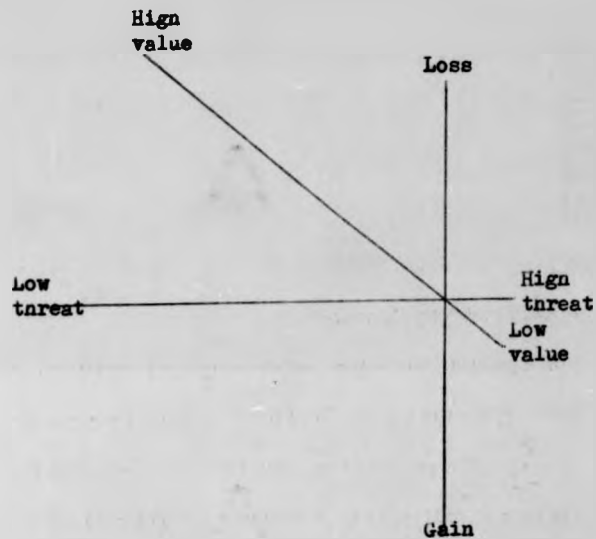


Diagram 6. Mr. Archer's view of giving up gardening.

While the illustrations just quoted have an internal consistency about them, the model offers a way of understanding some of the apparently contradictory views that the patients held and their ways of rationalising their intended behaviour. Mr. Fraser, for instance, who wanted very precise instructions from the doctor and intended to keep to them, said when talking about his plans to keep in touch with his work "Of course, I'd want to do that. In fact, if the doctor tells me 'no', I shall still do it. I won't tell him that, but I will do it, because it's most essential." He was expecting to be told that an early return to work would constitute a High Threat, but because it was invested with such a High Value, he tried to rationalise this away, saying "I'd feel worse ~~not~~ going in." Similarly, Mr. Langton, who had been told by the doctor to stop smoking and drinking - both being presented as High Threat - decided that he would stop smoking, but that drinking was too high on the Value scale because of its social connotations; the Loss would therefore seem too high and to resolve his dilemma, he tried to reduce its Threat content.

Dieting, smoking and drinking featured frequently among the patients' specific predictions for the future, all of them being issues over which they felt the doctors made definitive statements. Some of the comments connected with these areas introduce another element into the Threat - Value - Gain/Loss model. This demonstrates the setting of a decision about a particular activity within the context of another and often greater value scale. Both Mr. Irwin and Mr. Neale saw the need for a strict diet as high on the Value, Loss and Threat scales - it was going to be very difficult for both of them. Mr. Neale, though, was determined to keep it because "I think too much of my wife." In relation to her, the diet dropped on the Value scale, and there was also a high element of threat to her happiness and well-being if he became ill again. Mr. Irwin's wider reference point was his view of the over-all quality of life. He said that, while he intended to keep the diet, "If I can't have what I like, life's not worth living" and he would modify it.

Although some of the illustrations that have been quoted contain an element of Loss, which was often perceived as high, it is interesting to note that at

this stage of the illness, many men were stressing the potential gains that they hoped to achieve and speaking of potential losses in very neutral terms. The fact that this emphasis was later modified seems to highlight the fact that it was an initial response to the sense of threat to their lives in order to preserve life almost any loss could be tolerated with equanimity. Many thought that they were going to be more healthy in future. Mr. Cook - "It's done good in that way, because I've been trying to lose weight." Mr. Jessop - "It's a good thing this has happened - I could have carried on then had a bad one without any chance. This is going to teach me a lesson to slow down." Many thought that they would take the illness as "a warning" and intended to establish a new pattern of health behaviour for the future. Mr. Fraser, Mr. Keogh and Mr. Langton all planned to take regular exercise, Mr. Mears to drink less and so on. The phrase running as a chorus through these predictions was "as I don't have to come back here." On a general view, then, the new health behaviour was being seen as a Gain even if it meant abandoning highly Valued activities as if reduced the level of Threat.

Two other particular aspects of Gain which are worth mentioning briefly came when the illness could be seen as a way of achieving some other desired goal. Mr. Mear's domestic situation has already been described, and it is not surprising that he saw the illness as a means of achieving an improved relationship with his wife. Both Mr. Cook and Mr. Gould expected to achieve Gains in the work context. Both had been working in understaffed sections at work and had thought that the amount of over-time that the firms demanded was excessive. They felt that the illness had now proved their point and the firms would have to take notice. Mr. Cook was delighted when his colleague went to the management and said "'I should think you're satisfied now you've done this to Mr. Cook'....Mind you, I say it's all through this overwork, but at the same time I know it could be because I'm grossly overweight. Now it could well be that that has brought all this on, but I'm not going to tell the firm it could be - or I'll still be doing three men's work when I get back - I'll never get anybody to listen to me."

The patients' expectations of a prescription for their future from the doctor has already been discussed in the previous chapter. In the context of the present discussion, this need can be seen as a way of giving them an authoritative statement about their general position and the position of specific activities along the continuum of high and low Threat. Mr. Irwin, another devoted gardener, hoped the doctors would resolve his uncertainty - "But I won't be able to do....No, I won't say that as I don't know what I am going to be able to do....it depends what I'm like....if they say I'm all right...."

The uncertainty which hangs over all these predictions was a direct reflection of the confusion within the patients' minds. Modifications to their attitudes occurred even within the length of time they were in hospital, and will be seen to change further during their future progress. Many of the elements of the decision process, however, will be seen to continue.

c) Their views on their wives' situations and roles.

Almost all the men realised that their wives were worried, although the timing of the realisation varied. Mr. Neale described his wife and son as "both shocked - they didn't realise it was so serious." For them, the anxiety began with his diagnosis and admission, and they had communicated it to him. Mr. Maston and Mr. Keeghan both came to realise later how worried their wives had been - "She was worried at first, but she hid it - she wouldn't show it - she doesn't show her emotions very much, at least not to me....but I came to realise" "I think she's taking it very sensibly. She doesn't show worry a lot - I think she worried at first - she's told me a little bit now you see. She's always been all smiles and that when she's come, but she's said 'I know you weren't very brilliant!'" Mr. Gould, who had found some relief from sharing his worry with another patient, admired his wife's capacity not to show her worry "She's worried now, but she won't show it, because she knows it will worry me. I'll get to know if she's worried from the daughter, but I'll never get to know it from her....it's a good thing if one can hide one's worry."

Only two men thought their wives were not worried. Mr. Hewitt - "I'm surprised she didn't seem more worried", indicated by this that he had not seen through her carefully constructed facade. Mr. Gould who has been quoted above as knowing his wife would hide her anxiety, later came to the conclusion that she wasn't worried and didn't think he was seriously ill.

Therefore although most of them recognised the pretense (Glaser and Strauss (1965)) for what it was, it was a pattern of interaction that seemed to satisfy them, and was sometimes even thought to have benefits. The patients, in fact, often played the same 'game' (Berne (1964)), assuming the protector role to shield their wives from anxiety. Mr. Keoghan and Mr. Archer both withheld symptoms of pain that they were having and Mr. Gould didn't try to persuade his wife of the seriousness of his illness, all "because I didn't want to worry her."

This collusion to deny anxiety seemed to satisfy both partners, largely because each thought that they could 'see through' the acting of the other while being sure that their own facade was completely adequate. Several reasons for this apparent satisfaction could be suggested, but the one which seems most relevant to the present theme is that each found the reaction and situation of the other possible to conceive of and could therefore, by drawing on their past knowledge, imagine the range of feelings they would expect the other to have. Many patients spoke of their concern about the strain on their wives "she's dashing about too much", "I'm worried about her driving home in the dark", "I'm relieved she's got some company" and so on. Most thought that they knew the situation at home in considerable detail, although Mr. Easton was one who later said that he had underestimated the extent of the disorganisation at home at the time of his illness. On the whole, though, they thought that they could imagine the situation and predict their wives' responses. This, it is therefore suggested, is because the sick role and the behaviour of others towards the sick person is relatively highly institutionalised. The lack of communication about what was being experienced therefore did not matter to them very much. In the later stage of convalescence, it will be seen that the pattern of selective communication

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continued, but it will be suggested that because the behaviour of both parties was more ambiguous, the pattern then became more problematic.

When asked to predict the roles that they thought their wives would play in relation to their convalescence, most patients were rather vague. Only Mr. Barry who had a long standing difficulty in his relationship with his wife, thought "she will nag", to which he reckoned he would respond by "I'll go out if I can't bear it." Mr. Gould and Mr. Irvin both thought their wives would try to limit their activities - "She'll try to stop me, that's obvious", but in the next interview, Mr. Irvin thought there would be more to it than this - "If she thinks I'm doing too much it'll be up to her to tell me and I'll have to decide whether I am or not. We'll discuss it - if she thinks so, she'll tell me....She'll just stop me I suppose if she thinks I'm over-doing it. I take notice of her. She knows how I feel and how I look - she's known me for long enough. I'll have to respect her views, if she thinks so, well that's it." On another occasion, he said when talking about working in his treasured greenhouse, "Let's put it this way - how will she be able to stop me?" Mr. Heale questioned whether his wife had the necessary knowledge to be a final arbiter - "My wife and son, they keep saying 'You've got to stop doing this, and you've got to stop doing that, - but have I? That's what I want to find out.'" These views were representative of many patients both in assuming that uncertainties would be discussed and also in the difficulty of knowing who was going to be the final arbiter. This assumption that communication would be possible in this area, when they were at the time operating on 'pretence' communication is extremely interesting. While it could imply that they expected a new pattern to be established because of the changed situation when they returned home, it seems more likely that it indicates that they did not realise how much worry and anxiety there would be over day-to-day decisions; worry being the main thing that their present communication excluded.

In summarising this final section which has dealt with the patients' experiences and perceptions, it is noted again that this has involved a marked change of focus from the early parts of the chapter; a change from the

role-set influencing the patients to the patients themselves, - while keeping all the actors still on the stage. In the discussion of their perceptions of the illness and their recovery, the theory of crisis has been developed. Their expectations for the future have suggested a model for analysis in which Gain - Value - Threat continua intersect at different points for different discrete behaviours. It was seen that in the turmoil of the crisis and recent risk to their lives, almost any change in their behaviour was felt to be tolerable. Their views on their wives' situations sets out the other side of the coin from the wives' views which were discussed earlier.

III. Summary to Chapter 3.

This chapter has covered a wide range of empirical material that related to the patients' period of hospitalisation. It has moved around the four units of the role-set and then focused onto the patients themselves. Unlike most studies of hospital patients, it does not see this period as complete in itself, but has reflected the meaning that the patients gave to the period, that is, that it was the first of a series of stages and that much significant action lay in the future. In doing this, it has been both the first illustration of the orientation to the research which was described in the first two chapters, and has introduced the Longitudinal and Lateral dimensions of the process, which will continue to be a central theme.

The experience of hospitalisation and socialisation into being a cardiac convalescent have been seen to contain contradictions and ambiguities which will be examined again during the later stages of the longitudinal process. The period of time that has so far been covered has been extremely brief, on average just under fourteen days, but has been crowded with experiences and meanings. From now on, the time-sequence is more extended, and longitudinal movement, correspondingly, becomes increasingly important. At the same time, the return of the patients to their own environments leads to a sudden development of the lateral dimension. The movement on these two planes and the interplay between them gives the framework for the remainder of the thesis. The concept of convalescent behaviour will be elaborated in chapter 4 in order that the proposed theory may be understood before the remaining empirical data is presented.

4. TOWARDS A THEORY OF CONVALESCENT BEHAVIOUR.

This chapter is central to the thesis in that it creates a bridge between the chapters that have preceded it and those that follow. The first three chapters have established a theoretical orientation and examined the period of hospitalisation in terms of a preliminary stage to the process of recovery. This has been seen to have its own dynamic and creativity and to have posed problems, the resolution of which lies in the patients' future experience. It is in following these experiences through into convalescence that this study is breaking new ground. The time-span is much longer than the phase of hospitalisation, and the movement and creativity are much greater. This dynamic cannot be overstressed in order to counter-balance the danger of the written word presenting static pictures. Where the theory of convalescence is set out diagrammatically, it would ideally require three-dimensional models which were capable of conveying movement and change. However, as this cannot be done on paper, it is necessary to carry the concept of movement in one's head so that the static diagram may be interpreted in this way. The chapter looks forward to the remainder of the thesis in that the theory being presented here will be worked out in the later empirical chapters.

I. The Convalescent Status.

Following Linton's (1936) classic formulation of the concept of status, theories of transition and of marginality have been added, both of which are relevant to the present discussion. Although these have been explored in relation to age, race, class, occupation and other social statuses, the transition and marginality aspects of status have not been fully worked out in the context of recovery from illness. In order to do this, it is necessary to assume that there is a Well Status from which an Ill Status can be differentiated. While recognising the difficulty of defining 'health' which is implicit in proposing a Well Status, some accepted definitions serve this purpose adequately. Mechanic (1959) quotes Hinkle and Wolff's (1957) operational definition of illness - "any symptom or syndrome that the American medical profession at the present time generally accepts as evidence of ill health" - meaning that good health implies the absence of these.

Apple (1960) emphasises the self-definition aspect of health - "when you yourself think you are sick." Baumann (1961) develops this.... "the concept that different attitudes towards health may reflect different meanings that are attached to the term. For some individuals, ability to carry on usual activities is central to their conception of good health. For others, good health is identified with "physical fitness", conceived as an absolute state attainable by following certain rules...." Patrick, Bush and Chen (1973) are concerned about the "value judgements that distinguish health from illness" and propose a definition by which "health status is a composite of an individual's level of function at a point in time and his expected transition to other levels, more or less favourable, at future times." If the themes of each of these were welded together, health would be seen as a consensus between the definers: medically, there is no identified illness, subjectively, he feels he is well. To this should be added a social dimension that others treat him as though he is well. These three perspectives are then placed in a historical context in which present health is related to the past and future. In this sense, the patients in the study had been in a Well Status before the crisis of their illness. The sample criteria of excluding a history of treatment for heart disease was relevant here. That health is not generally taken to be a significant definer of status would seem to be because it is usually assumed that populations under study are Well, and thus it is only when this assumption is negated by an episode of identified illness that the Well Status is seen to be meaningful.

In considering the transitional status aspect of convalescence, it is necessary to remember that the Ill Status from which the patient is moving has been characterised by acute abnormality. This abnormality has disrupted his usual social functioning, either by suspending some of his other statuses, as, for instance when he is no longer being paid as an employee, or by rendering him unable to carry out the tasks usually associated with his usual roles, even though the role relationship may continue, as in instances when his children visit him but he cannot pick them up to hug them. Both the patient and those with whom he interacts expect this acute abnormality

to be time-limited, and over this there is consensus. The extent to which he can be expected ultimately to return to a Well Status, equivalent to his previous one, is presented to him and perceived by him with considerable diversity and contradiction. However, even greater uncertainty surrounds the process by which he must move from the recognised Ill Status to the uncertain Well Status. The transitional nature of the stage is not even recognised, far less marked out with accepted rites of passage. Nor is it always at all clear when the process should be considered to be completed as the process moves at different speeds for different spheres of his social world. If adolescence is considered as a parallel transition, (Lederer 1952) coming-of-age may be equated with medical certification to return to work, but this administrative demarcation makes little difference to the way Self and Others view his stage of maturity and capabilities, or, in the medical context, his state of health and activity. Each role-set member, while influenced by the definitions of others, still needs to reach his own conclusions about when the process may be considered completed. This view of a transitional status allows sense to be made of the otherwise random and meaningless fluctuations backwards and forwards that occurred throughout the recovery period in areas such as values, self-definitions and attitudes as well as in observable behaviour. While such fluctuations are to be expected in any transitional state, it is important to note the additional factor that was found in relation to convalescence, that is, that the end state towards which they were progressing was itself uncertain. In contrast, therefore, with the adolescent who moves towards adulthood which he can conceptualise and for which he has models, the convalescent had conflicting ideas as to what he could hope to attain to. His attempts to clarify this, led him both to review continuously his past and expected future and also to re-evaluate the interplay between these and the uncertainties of his present. A diagram of the transitional aspect of convalescence would look like this:-

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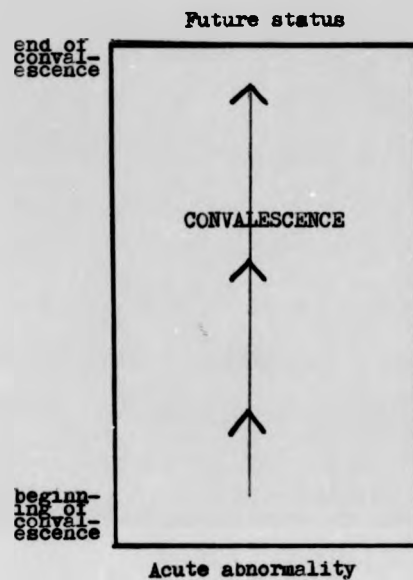


Diagram 7. Convalescence as a transitional status.

Thus, transition implies the movement which is so central to the concept of process. In the diagram, the movement is shown upwards by arrows from the acutely abnormal state towards a future in which health and social status are still uncertain.

The concept of marginality adds a different but related perspective. Although originally applied to ethnic and occupational statuses, it has value in analysing many other ambiguous spheres of human experience. In arguing that recovery forms a marginal status, it is suggested that the two constituent elements - the Well Status and the Ill Status - are theoretically mutually exclusive and yet during this process must coexist. An optimal state of tension between them promotes the transition from the Ill to the Well. Diagrammatically, marginality can be depicted thus:-

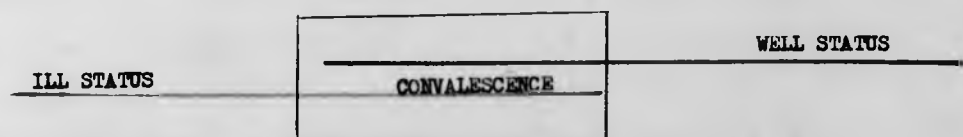


Diagram 8. Convalescence as a marginal status.

Even more than racial marginality, health marginality is vulnerable to having its internal contradictions compounded by the variety of perceptions of it which are presented by other people. The lack of consensus about the roles and behaviour that are appropriate to a convalescent person reflect the underlying uncertainty about his status which others communicate to him. Yet at the same time, because of his own discomfort with the ambiguity of the status, the convalescent may want and seek out such prescriptions to confirm to himself that he is occupying it in a suitable way.

Because marginality and transition exist together, the diagrammatic presentation can now be elaborated to show them in relation to each other. In this way the movement and the ambiguity are portrayed together. While recognising that any diagram risks doing violence to complex and fluid data by presenting it as uni-dimensional and static, a theoretical ideal of the convalescent status, as an abstract conceptualisation would look like this:-

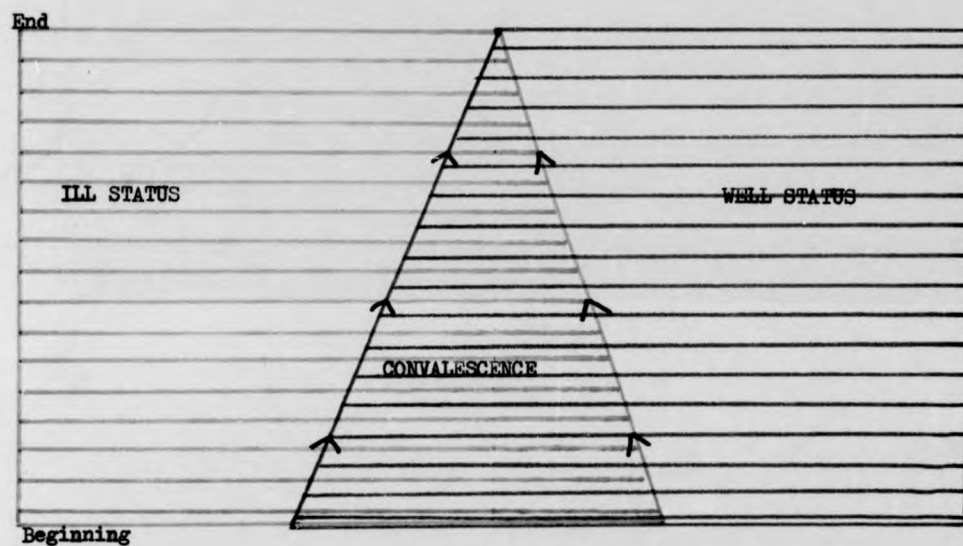


Diagram 9. Theoretical ideal of convalescence as a transitional and marginal status.

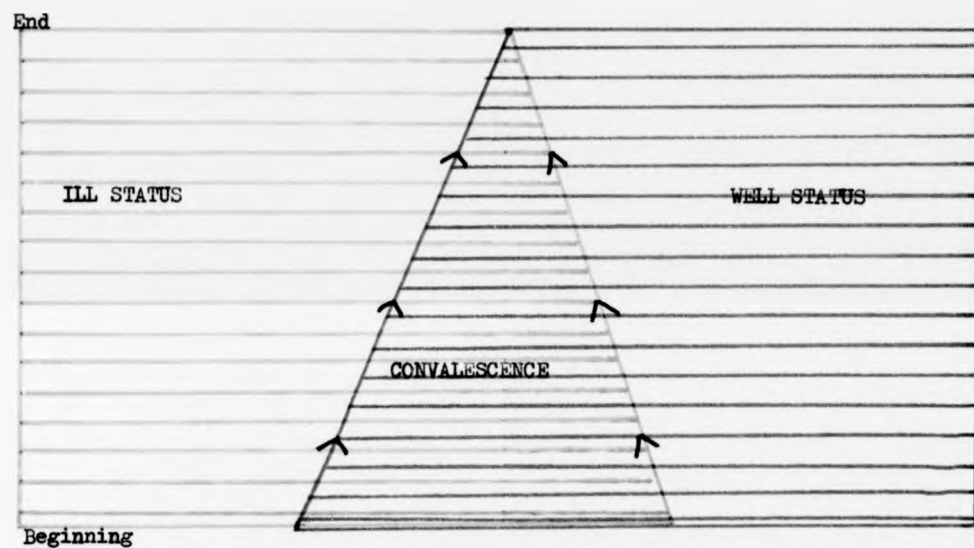


Diagram 9. Theoretical ideal of convalescence as a transitional and marginal status.

However, the real world in which people live and have their experiences is not an ideal one and the satisfactory resolution of marginality with the transition of time does not ring true to the patients' experiences. The data that will be discussed in the following chapters will indicate how much uncertainty about health status remained even at the end of convalescence. In order to allow for this continuing ambiguity, the diagram will now be redrawn so that the Ill Status and the Well Status continue to co-exist throughout the time period of convalescence.

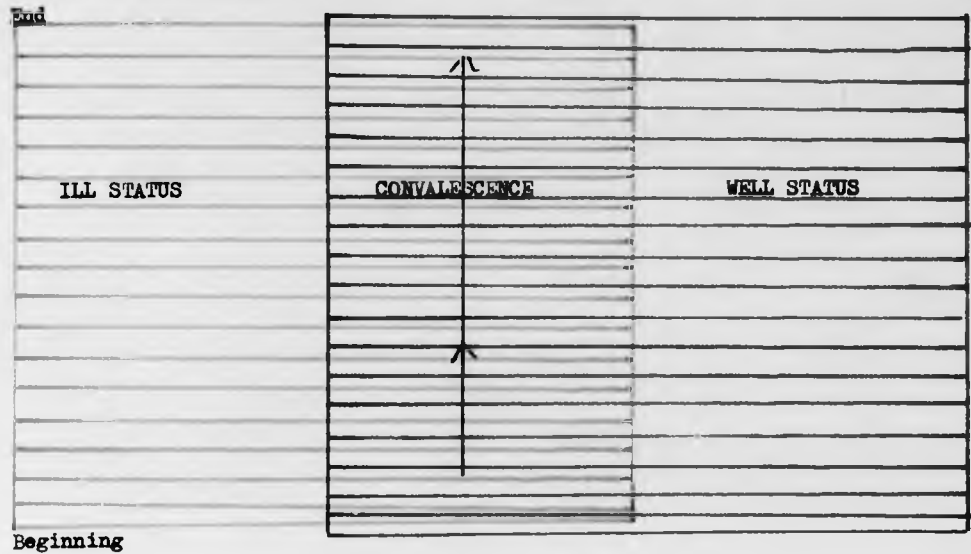


Diagram 10. Convalescence in reality containing continuing ambiguity.

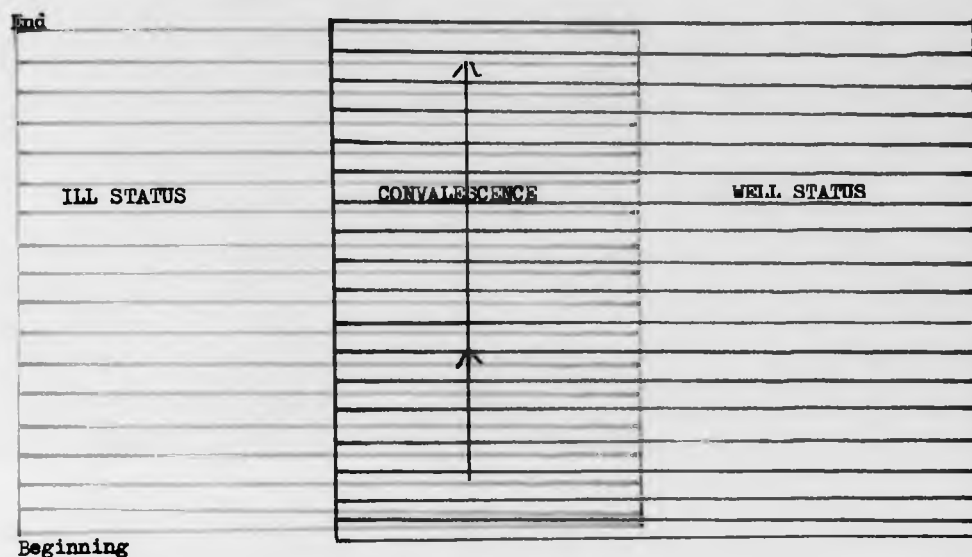


Diagram 10. Convalescence in reality containing continuing ambiguity.

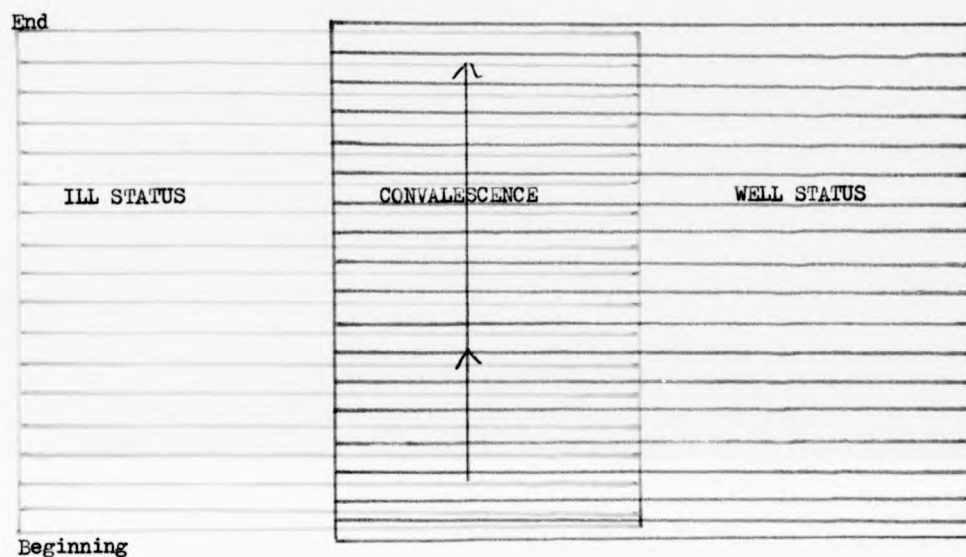


Diagram 10. Convalescence in reality containing continuing ambiguity.

On the basis of this diagram, which allows for continuing ambiguity of health status throughout the time period, the concept of process can now be superimposed. This refocuses the idea of movement away from the statuses, per se, to the passage that any individual may take through acute ambiguity to a resolution which may still have ambiguous features. By portraying the movement diagonally, it can indicate that at the beginning of convalescence, the status position and related behaviour is mostly in the Ill Status, with only some aspects in the Well Status; by the end of convalescence, the situation is reversed, so that the individual is mostly in the Well Status, with perhaps some continuing tenure of the Ill Status. The model, while still presented as a conceptual abstraction, is more faithful to the patients' experiences than was diagram 9, as it allows for uncertainty to remain throughout the transition with the result that some parts of the Ill Status may still be operational at the end. The breadth and 'angle' of movement that the next diagram implies is therefore capable of individual variation.

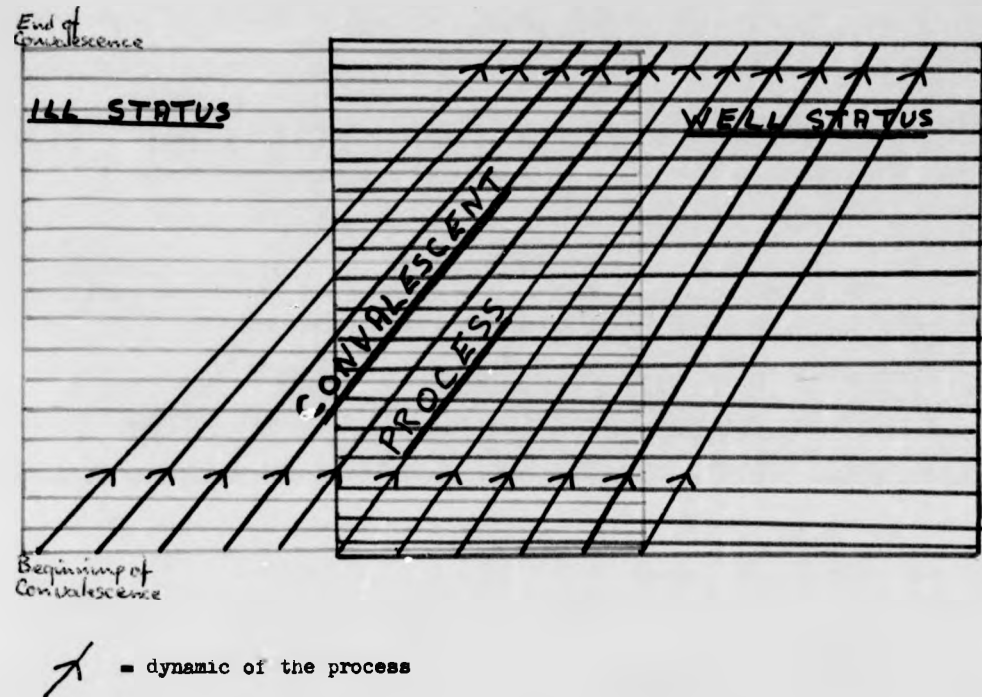


Diagram 11. The convalescent process - as transition through status ambiguity.

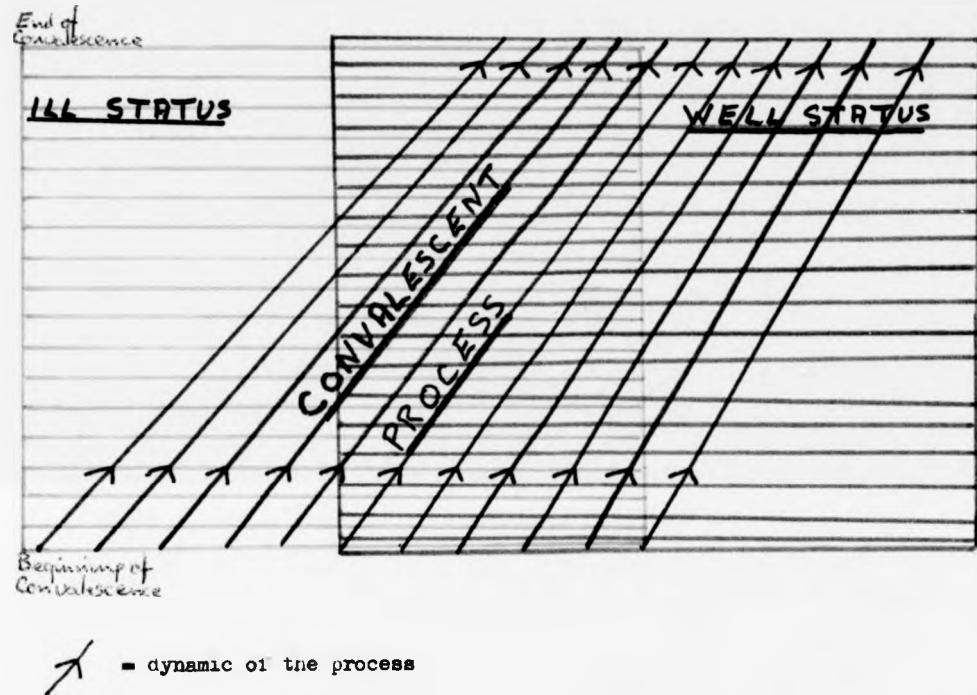


Diagram 11. The convalescent process - as transition through status ambiguity.

It is this last diagram, which has related process to status position, which will be used as the basis of the argument that now follows. Both the text and later diagrams are an elaboration of it as the complexity of convalescence is more fully explored. When the discussion focuses onto the choices that had to be made about behaviour, the same diagram is used, with the outer diagonal lines then demarcating the range that was perceived to be appropriate.

Having examined the transitional and marginality aspects of the statuses that comprise convalescence, it is then possible to turn to a discussion of the ways by which this passage through convalescence are perceived and followed, the influences affecting the process, and the behavioural choices that result from these.

II. Convalescence as a Process.

Process as defined in Chamber's dictionary as, among other things, "a state of being in progress or being carried on....a series of actions or events....a sequence of operations or changes undergone." To speak of convalescence as a process, therefore, must imply that is a dynamic, changing state, and also that it had both active and passive elements. Both these features are central to the theory which is being proposed, and underly the analysis of the data even when they are not explicitly stated.

The process of convalescence may thus be defined as the passage through a period of time during which health status is uncertain and changing. The model that each individual holds of the roles and behaviour that are appropriate for him both reflect his view of his present in the light of his past and expected future, and also evolve from the interplay of his own perceptions with the models presented to him by others in his role-set. This statement needs some fuller elaboration along longitudinal and lateral dimensions.

a) The longitudinal perspective is based on the assumption of an individual's life experience having an essential continuity; this presupposes that his past influences his present and future, his view of his future affects his present, and both of these in their turn promote reinterpretation of his past. However great the change or dislocation of his social circumstances,

through migration, occupational mobility, or, in this case illness, past present and future continue to interact. To argue this is in keeping with Cohen and Taylor's (1972 pps.147-8) criticism, in a prison context, of Goffman and others of the 'dysfunction of institutions' school, who tend to assume the pre-institutional self loses its importance, that a new identity is created which has more claims on our attention." They write "It is not just the history of the wing that is important to the inmate culture; we must also take account of the history of the men who make up its population." While this link between past and present can be established from such literature, the connection between these two and expectations of the future is as yet relatively unexplored. Its relevance is recognised by Kluckhohn and Strodtbeck (1961) when discussing Popular Health Culture, who viewed a past - present - future time orientation as one of the value criteria affecting health behaviour. Support for the concept of this future - orientation can also be found in Wright (1960), who compares 'asset' values with 'comparative' values in their effects on present and future achievements. In doing this she goes beyond a clinical assessment of the limitations imposed by a medical condition to discuss the ways in which an individual perceives the condition according to its effects on his goals and values.*

*Footnote: While the significance of values is increasingly recognised in much medical-sociological literature (cf. Davis (1963), McLachlan (1972), Miller and Gynne (1972), Pill and Jacobs (1974)) it is more usual for discussion of "the quality of life" to focus onto extreme medical situations. Issues surrounding the decision to save the life of Spina Bifida babies or prolong the life of those with severe head injuries reflect the values of the decision-makers. The institutional care of the severely disabled reflects social and organisational values which affect the quality of life to which the residents can aspire. Pill and Jacobs covered a wider range of 'severity' of conditions, and write "Those who are most severely impaired will have limited expectations of attaining social competence i.e. the ability to achieve and perform in valued social roles" (p.26). Although this assumption that the socially accepted values of others will be adopted by the child

In the context of this discussion, this means not only that his pre-illness circumstances, experiences and values play a part in shaping his perceptions of his present and his expectations of his future, but also that his view of his future health influences the way he understands his present and behaves in it. The limitations of investigating a 'pre-illness past' retrospectively have already been discussed in chapter 1, and this is referred to again in the discussion of the empirical data. However, a longitudinal perspective takes on a new significance when the research design is itself longitudinal. When each interview series began, the acute illness was the present and the convalescence and return to a Well Status was the future; this was the stand-point from which the patient saw his own time scale. Later in the series of interviews, the illness itself had become 'past', and by the final interview, some respondents viewed the whole of convalescence as 'past'. The continuing and changing aspects of the experience can be traced like coloured threads in a woven pattern, highlighting the dynamic processes over a period of time.

This longitudinal view, however, must not be seen mechanistically as though both the period of time and its ending were clear-cut or predetermined. The ambiguity that has been shown to characterise the convalescent state, affects also the length of time that it is expected to last and the way that the end of it will be recognised. It is important in this context to remember that convalescence and the research project were not co-terminous, and that not all the patients had reached their subjective end by the date of the final interview. Thus the longitudinal aspect of process could be either shorter or longer than the period of research.

*Footnote (continued)

patient, may be acceptable because he is a child, it does not allow for the possibility that the child may develop different values. There remains a need for an empirical study of how an individual's goals and values for the future interact with his present medical condition.

Uncertainty is therefore the hall-mark of this longitudinal dimension, as although in theory it is as much medically determined as is the length of hospitalisation, both of these periods are affected by the interplay of social factors.

b) The lateral perspective of the process of convalescence must be seen in relation to the longitudinal view, with the two in constant interaction. The career of a patient through the chronological stages of illness and recovery could seem to be an individualistic biography unless the whole process is firmly placed in its social context, with the individual as a member of his social group. The failure of much medical sociology to do this, is a criticism that recurs throughout Sussman's (1966) *Sociology and Rehabilitation* and is especially stressed by Klock (1966) in his argument for the study of the doctor and patient participants "within a role-expectation social system frame of reference." It is an recognition of the importance of the individual's social context that this lateral view is given as much weight as the longitudinal biographical view in this study.

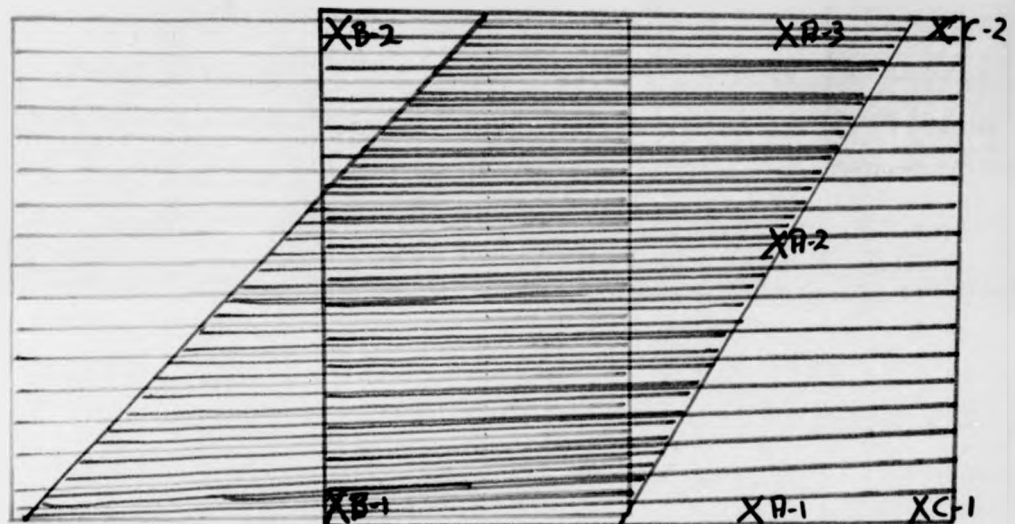
This general statement about the lateral, social context of the process of convalescence demands some further exploration in terms of the ways in which it affected and was affected by the individual's health position. This more concrete discussion will focus onto two distinct but related areas which will be considered separately and then placed in conjunction. The first area is concerned with the range of the individual's roles, relationships and behaviours within his role-set and 'social space'. The means by which he decides to resume or initiate activity within his 'social space' will be suggested. The second area concerns the reciprocal influences within his social group which affect his choices and behaviour. These are somewhat artificially distinguished for the purpose of argument.

Considering the first point, which concerns his own decision-making activity about the range of 'social space' that he will occupy, it must be noted that, once he leaves hospital, the range of activities open to him widens suddenly. In theory, he could resume all his usual roles and activities subject only to the medical/administrative constraint against returning to work and such physical symptoms as pain and fatigue that he experiences.

which are in themselves often subjectively defined. Yet he does not do this; he selects behaviour that he considers to be appropriate to the stage that he considers that he is at. In making these choices, he is both reflecting his perception of the current balance between the contradictory elements of his health status, and also indicating his investment in different aspects of his repertoire of normal activities. A model of the interrelation of Threat - Loss - Value elements in the consideration of any particular activity has been suggested, in the previous chapter, as a means of understanding the patients' variable predictions about their behaviour when they were looking ahead to their convalescent period. By continuing to use the same model to examine their actual as opposed to their predicted behaviour, it is possible to trace movement and change in their perceptions and the grounds on which decisions are made. These apparently discrete decisions are viewed as having significance because they are placed within the general pattern of the decision-making process.

While the rating of any particular part of his behaviour repertoire on the Loss scale may show some change throughout the time-span of convalescence, considerable changes are likely to occur in the perceived Threat and Value rating of it. To present various choices diagrammatically below: Activity A, for instance gardening, may be seen differently at different times. At point A-1, it may be high in Value, high on Loss but also high on Threat, and therefore excluded from activities being undertaken. At point A-2, some time later, it will retain its Value rating but because the Loss seems too high and the Threat is somewhat less, it will be included at least in moderation. By point A-3, the Threat has diminished even further and the Value and Loss elements can be forgotten about. Activity B, for instance working on a stamp collection, may be included at point B-1 in early activities even though of low Value, because it is low in Threat but has an element of Gain because it helps pass the time. As convalescence proceeds, it may be abandoned because the time can be filled with more valued activities and it can be rejected with other illness-orientated behaviour - point B-2. Activity C, which might be some strenuous task such as painting the outside of the house, might remain outside the range of resumed activities whether or not it features high

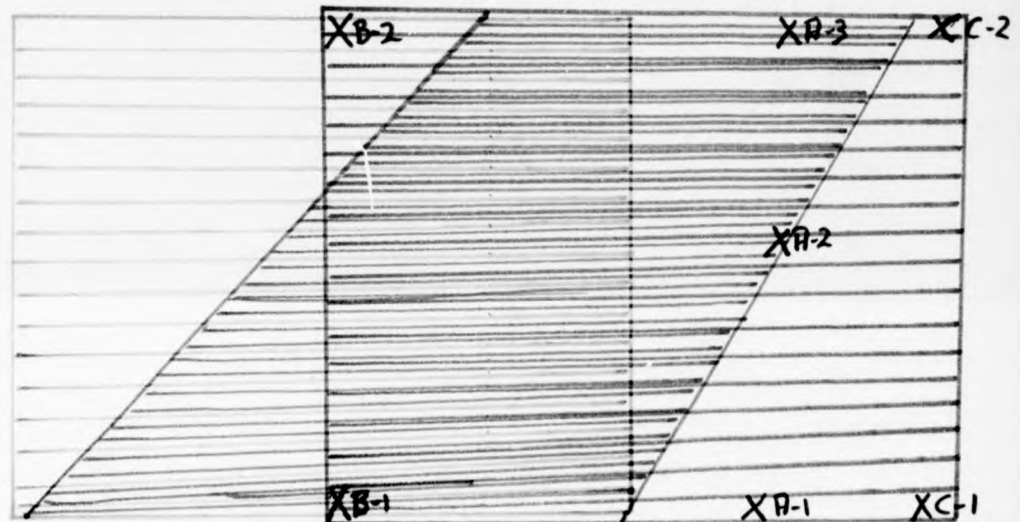
on the Value and Loss scales because the Threat element remains too high; points C-1 to C-2.



☐ * activities selected by a patient from his potential repertoire.

Diagram 12. Changes of decisions about appropriate activity.

on the Value and Loss scales because the Threat element remains too high; points C-1 to C-2.




 activities selected by a patient from his potential repertoire.

Diagram 12. Changes of decisions about appropriate activity.

This discussion of the choices that a convalescent person makes about their activities logically demands some scheme by which behaviour can be categorised. To do this on intangible criteria such as perceptions must inevitably result in a looser classification than if for instance physiological measurements of cardiac function related to types of exercise were being done. (e.g. Broula 1959) The categories suggested have extremely indefinite boundaries, and merge and overlap rather than have clear cut-off points.

[illegible]

Diagram 13. Categories of behaviour.

The continuum that runs through these categories of behaviour can be termed Invalidity - Recklessness, but in this again both perceptions and the time factor are important. The terminology being used reflects their own views of different types of behaviour, and does not carry any medical connotations of invalidity. For the individual seeking his appropriate behaviour, both ends of the continuum will probably be rejected, although this chosen 'middle path' will move further from the Invalidity and towards the Recklessness end as time proceeds.

The designation of any particular activity to a category is in this sense the individual's perception of the lateral boundaries of his permitted behaviour. Because he does not make these decisions in isolation, the second aspect of the lateral dimension of convalescence must now be considered.

This second area of the lateral dimension concerns the reciprocal influences between the convalescent individual and other people in his social group concerning the roles he should play and the behaviour that is appropriate. Each member of his role-set holds his own model of the duration and shape of the convalescent process and has some degree of investment in seeking to influence the individual to conform to it. Some parts of the role-set are a continuation of relationships from his pre-illness past, and the particular characteristic of each relationship gives meaning to the desire to influence his behaviour. Thus, while both the wife and employer may hold nearly identical models of the convalescent process, their differing degrees of involvement in the relationship may give rise to both quantitatively and qualitatively different forms of influence. Many of the pre-illness role-set can not be expected to have personal experience of recovery from a heart attack, although they may use parallel experiences to give weight to their influence. In contrast, the newly acquired role-set, comprising the medical personnel and the 'cardiac wise' can claim greater authority in presenting their models. Their relationship with the convalescent person is, however, more likely to be focused onto the health aspect of his life without a wider or more personal involvement. The exception to this separation of

pre- and post-illness role-sets are the relationships with relations or friends who had had heart trouble; these were pre-existing, but takes on a new dimension because they are also the 'wise! The diagrammatic scheme now has an additional feature:-

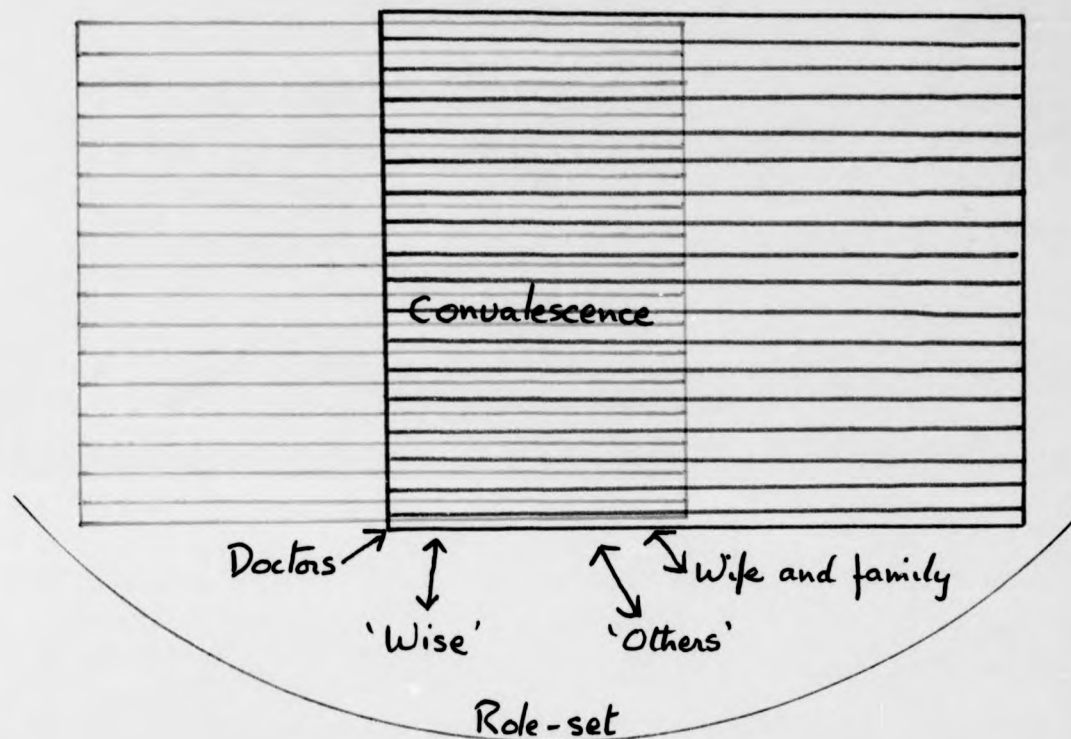


Diagram 14. Influences of the role-set.

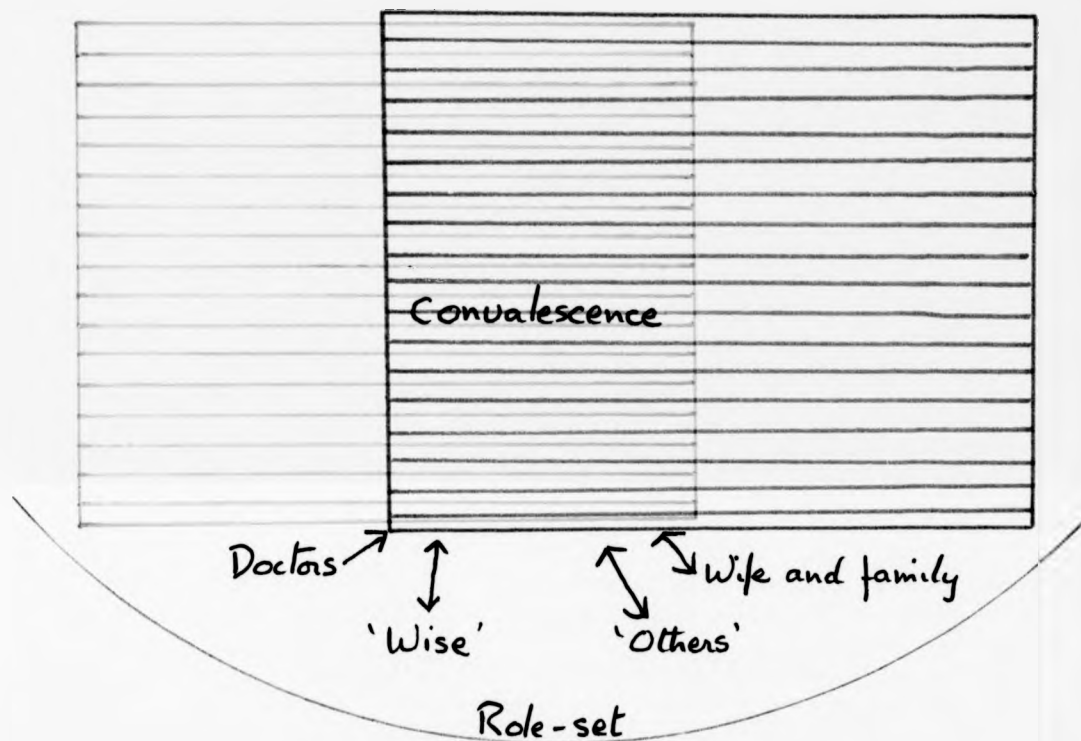
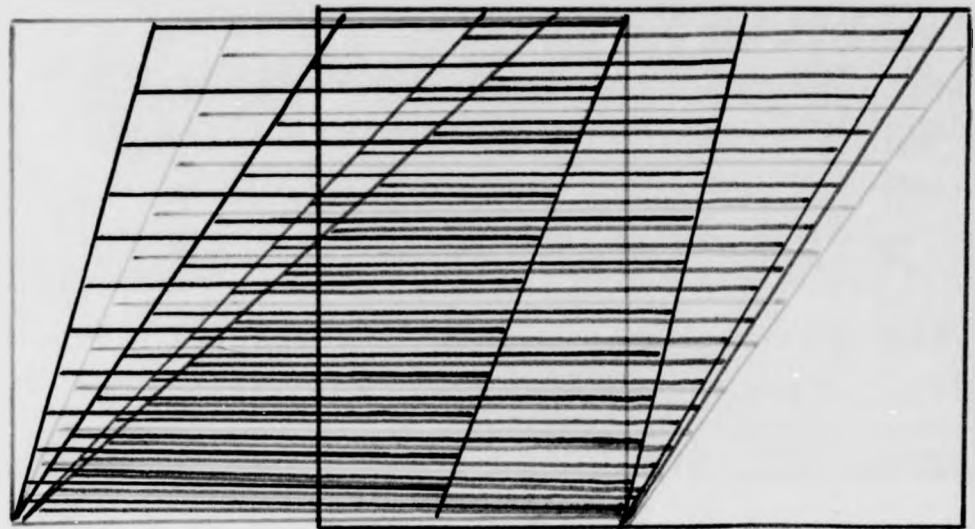


Diagram 14. Influences of the role-set.

Each member of the role-set holds some model, whether based on knowledge, experience or 'common wisdom', as to how the process of convalescence should be conducted. Each of these models not only contains internal contradictions within itself, but most are at variance with each other. These discrepancies will be discussed in the following chapters in some detail, and for the moment it is sufficient to note that each convalescent individual was subject to a number of contradictory influences. If a diagram, which concerned the selection of activities from the possible repertoire, were drawn for each individual convalescent and also his perception of the model held by each person in his role-set who tried to influence his behaviour, and then this set of profiles were superimposed upon each other, the resulting confusion might have been seen in this way:-








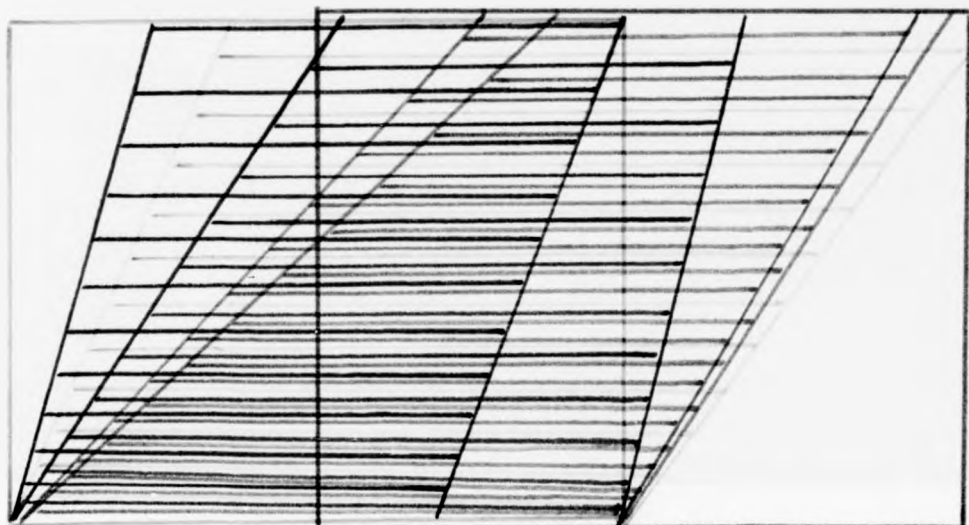
-  = Patient's model
-  = Medical model
-  = Wife's model
-  = 'Wise's model
-  = 'Other's model

Diagram 15. Discrepant influences.








-  = Patient's model
-  = Medical model
-  = Wife's model
-  = 'Wise's model
-  = 'Other's model

Diagram 15. Discrepant influences.

While it cannot be suggested that equal weight is given to each of these influences, the actual balance between them varies in each social context according both to the degree of authority assumed by or imputed to the influence, and also by the use that the individual wished to make of the advice at any point in time. This concept of the individual needing and seeking out the models held by members of his role-set, in order to clarify or confirm his personal model is discussed in more detail in the later chapters.

Although in some ways this diversity can be functional, the tension between these disagreeing models can also create confusion and anxiety. It is suggested that there may be an optimum level of tension which is functional in keeping the process moving. If the tension becomes too great, communication breaks down and interchange and creativity are lost; if the tension is too little, there is a lack of stimulation resulting in the institutionalisation of what is meant to be a dynamic process. It is in this sense that the two aspects of the lateral dimension of the convalescent process must be seen as interacting.

III. Summary.

Convalescence has been shown to contain major ambiguities of health status, in which transition and marginality must be resolved. The concept of process has indicated some of the tasks which are involved in this resolution and the influences which interact in achieving it. The two dimensions of time (longitudinal) and range (lateral) have been developed more fully than before; because the interplay between them is so significant, they must be held together theoretically even when separated for the purpose of analysis.

As indicated in chapter 1, this theory of convalescence has been generated from the empirical data. It has been presented before the remainder of the data so that it might be set out as a whole and offer a framework for the understanding of the later chapters. These chapters examine the patients' experiences of convalescence and, in doing this, illustrate and develop the theory. They are organised in a way which largely

follows the ordering of the material in chapter 3, that is, they discuss the influences of the role-set and the uses that were made of it before turning to the patients' own views. Chapter 5 considers the influences that were reported by the patients and wives; reports that reflect their own perceptions and interpretations as these units of the role-set were not themselves interviewed. Chapter 6 discusses the wives' experiences both as they themselves described it and as their husbands reported it. The final empirical chapter, chapter 7, focuses on the patients' experiences and the ways that the role-set influenced their convalescence.

5. THE INFLUENCE OF THE ROLE-SET.

As indicated at the close of the last chapter, the process of convalescence will be studied first in terms of the units of the role-set which influenced the patients. While this gives major emphasis to one of the elements of the lateral perspective, i.e. the relationships of the role-set, it will be seen to carry with it implications for the narrower use of the lateral concept, the decision-making about discrete activities, and also for the longitudinal dimension.

Three units of the role-set are discussed in this chapter; the medical, the 'wise' and the 'others' - terms which are being used with the same meanings that were given to them earlier. The views held by these groups are known only as they were reported by the patients and their wives. Because of the orientation of the research, this is in no way a disadvantage, as the significance of these influences lies in the use that the chief actors made of them. The chapter is organised in three sections, one for each unit that is being discussed. The views that are perceived to be held by each unit are presented as their model of convalescence.

I. The Medical Model of Convalescence.

It has already been suggested that both the husbands and wives looked to the doctors for authoritative statements about the convalescent period and expected their own interpretations to be shaped by this model. While the husbands had been in-patients, they had already experienced some confusion about the messages that the hospital staff were conveying. Although on their discharge, they ceased to have contact with staff such as nurses, thus losing one source of contradiction, at the same time their General Practitioner became active within their role-set, thereby subdividing this unit. Even if it was true that the hospital doctors presented a completely united opinion, the G.P. spoke independently. The extent to which there was real unity within the intended presentations of the doctors at the hospital cannot be assessed by this research. The usually accepted pattern of teams of doctors is that the consultant's policy both in general terms and over individual cases is accepted and propounded by his junior colleagues. There is therefore intended to be a high degree of consistency

within what they say to each patient, although the individuality of each doctor will mean that he may emphasise different aspects and may use different terminology. While very few of the research patients spoke of contradictory statements from within the group of doctors treating them in the hospital, it is possible to surmise that the pre-eminent position of the consultant meant that his statements alone were endowed with authority. Certainly it was the consultant's ward rounds that the patients looked to for significant definitions of their health and decisions about their treatment.

Most consultants wanted to communicate with their patients, and the difficulties that the patients experienced were more often making coherent sense of what they were told rather than not being told anything. This introduces a different aspect into communication problems from the ones highlighted by Cartwright (1964). One of the problems discussed in that study concerned the way that a multiplicity of sources of information could be used by the hospital staff to evade answering patients' questions. She quotes the words of a patient "The doctors wouldn't tell me anything. I asked the first in command, the second in command and they all side-tracked you. In the end they say 'Your local doctor will be informed; he'll tell you'". She continues "The gageness of these arrangements - the apparent lack of any clear responsibility for giving explanations - is likely to obscure from the hospital staff the fact that their explanations have been inadequate, unclear or misleading, since patients will often turn to another source for clarification or elaboration" (p.110). She goes on to discuss the difficulty for the G.P., both if the hospital's communication with him has been inadequate and if he does not know what the patient has been told.

The points that arise from this that are relevant to the present discussion are, firstly that even in a hospital that tries to communicate the messages that are received by the patients are contradictory; secondly, that there is uncertainty even among the staff about who is communicating authoritatively with the patient, especially between hospital staff and the G.P. and thirdly that the G.P. may be in a position of weakness because the

hospital have not shared both enough factual information nor the policy on which the patient's treatment is based.

It is within this context that it becomes relevant to consider the effects of the way that medical care is organised which results in the patients' discharge from hospital placing them under dual medical care: they continued to be out-patients of the hospital, being treated by the same group of doctors that they were under while an in-patient, but at the same time were 'discharged to the care of their G.P.'. Most patients showed considerable skill in mediating between these two sources of authority, perceiving the function of each in a way that was sufficiently close to the doctors' own views of their functions, to avoid friction. Stress was, however, experienced by patients who considered that their two doctors held very different policies about their treatment. They either had to choose between which they followed as authoritative, or else seek to synthesise yet another set of contradictions.

For the purpose of analysis, the two aspects of medical care will be considered separately.

a) The general practitioners.

It has been said in an earlier chapter that most of the men in the sample had not had serious illness before. Some of these had had contact with their G.P. over a period of many years, only for "a sick note when I had 'flu"; others had never seen their G.P. before. Being someone who did not go to their doctor was mentioned with an air of pride, and they felt that the doctors respected them for being a person who did not "bother" them unless it was a serious illness. Yet in spite of this minimal or totally absent personal contact between them, the G.P. was usually known to another member of the family. In all except two families, either his wife or the children had been treated by him, and he was felt to be a 'known' person. For some of the men, those whose heart attack occurred when they were at home, the way the G.P. handled the situation was thought by every one to be efficient and many spoke of the confidence he gave them. This generally positive attitude towards their G.P.s continued after their

discharge. This general impression is in keeping with Cartwright's (1967) study of general practice in which she states "The general picture that emerges....is of satisfied and appreciative patients" (p.9).

Although many patients spoke as though they looked to their G.P. only for prescriptions, for tablets and for National Insurance certificates, the use they actually made of them was more varied than this. At some times and over some matters, the G.P. was taken as the authority figure in a dyadic situation; at other times, such as the approach of a hospital outpatient appointment, or over other matters, the triad became operative, and within this both patient and G.P. looked to the hospital doctor as the greater authority. Both of these points need a fuller discussion; the ways the patients used their G.P.s will be outlined first, followed by a brief discussion of the triadic relationship.

Apart from the prescribing and legitimating functions of the G.P.s, the patients used them in three additional ways: they looked to them to approve the stages of their increasing activity, to give some reality to the time perspective of their convalescence, and to increase their understanding of their condition. Some G.P.s set out very clear-cut stages of activity, which even if the patients thought were unnecessarily restrictive, at least gave some substance to the vague instructions that the hospital had offered. In doing this, the G.P. could relate the activity to a known environment. For instance, Mr. Fraser's G.P. visited him at home a few days after his discharge - "I said to him 'I want to go out for a walk'. He said 'On Wednesday, I'll let you walk to the corner and back'. That was a bit of a disappointment really. I said 'You're joking - I walked further than that in hospital'. He said 'That's the hospital. You've got to take it in easy stages'." Two points are illustrated by this quotation; firstly that some G.P.s were prepared to be very specific and were helped in this by knowing the local situation. Mr. Fraser's G.P., for instance, knew how steep the hill was between his home and his local pub, and so could tell him that he must not attempt that particular journey for some weeks. Secondly, some G.P.s were more conservative over allowing their patients to

take exercise than were the hospital doctors. The comments arising from the first of Cartwright's (1964) studies that has been quoted are again relevant here. The G.P.s had little means of knowing the policy of treatment that the hospital doctors had been following, nor the exact stage of progress that their patients had reached. Much more detailed knowledge of both groups of doctors would be needed in order to be able to weigh the inadequacies in communication against other factors which might differentiate the ways in which cardiac treatment was conceptualised - date and place of training, interest in cardiac medicine, knowledge of and commitment to developments in treatment. Such factors would have needed a completely different form of investigation, and are therefore unknown features in the potentially different ways that each doctor conceptualised cardiac convalescence.

In setting the stages of progress, however, the G.P.s were able to be quite specific if they wished to be. They could say when the husbands could commence climbing stairs; they could forbid him to drive and later give permission for this. By no means all of them were so precise, but when they were, their instructions clarified many uncertainties.

The second major use made of the G.P. was to give some substance to the timespan that the convalescence would be expected to cover. The patients wanted a 'timetable' in a sense directly comparable with the T.B. patients in Roth's (1963) study. In offering this, the G.P.s sometimes reduced confusion and anxiety. Mr. Langton, for instance was reassured - "There was a time when I came out just over a week ago, when I began to think in terms of - in about 3 or 4 weeks Dr. C (at the hospital) said with a bit of luck, I'll be back at work. But I certainly don't think along these lines now. Perhaps I shouldn't say this, but my own doctor seemed to think eight weeks or more - that seemed more like it to me because I realise that I'm still terribly weak....I've still got a fair way to go." This patient had felt that there had been inadequate communication with the doctors at the hospital, that the convalescent period was under-valued and that he was being steamrollered along at an unreasonable pace. His G.P. seemed to him

to offer him greater individualisation and to be more realistic about both how much progress he yet had to achieve and also how long this should be expected to take.

For another patient, though, the G.P.'s time-table clarified a different kind of confusion. Mr. Neale left hospital thinking that he was cured. The hospital consultant had been "pleased with me" and had offered him reassurance that all was well. Mr. Neale had believed this, taking it in an absolute rather than a comparative sense, and expected to be allowed to return to work. "When I saw my own doctor, I asked if I could go back to work next Monday. 'Oh no' he says 'You may think you're all right, but you must have another month at least'. I had really expected to be signed off." Later in this same interview, Mr. Neale said "I didn't realise it was so serious until the doctor told me (about not returning to work yet).... I thought it was all over....the way I feel, I thought it was all finished with, but evidently it's not. You've got to give it time." Here, the nature of his illness and the present state of his health were redefined in an unwelcome way by the timetable that the G.P. presented.

These patients saw the G.P.'s timetable as highly personalised to their individual needs and situations. There were others, though, who expected the G.P. to act in accordance with his reputation for hurrying people back to work. Two such patients were Mr. Jessop and Mr. Hewitt. Mr. Jessop was in no hurry to be signed off as being fit for work as he wanted time to negotiate with his employers for the kind of lighter work that he wanted, and being "on the sick" was more acceptable to his self-image than being "on the dole - that's a different matter - I deplore it." After an appointment with his G.P. he felt he had had a reprieve, as the doctor had conceded to his view of the timetable - "I'm pleased I'm on the sick for another month." Mr. Hewitt also thought his doctor had a reputation - he "doesn't like people being on the 'box'", but unlike Mr. Jessop, he was quite happy if the timetable was shortened. He and his G.P. reached consensus - "The doctor was pleased with me. He said 'As far as I'm concerned you can start work, but I can't do anything till the specialist

says so - if the specialist says so, come back and I'll sign you off'." This last quotation will be referred to again below.

The patients' use of their G.P. to increase their understanding of their condition gave them a great deal of help in many cases. It was especially reassuring for those who felt that there had been inadequate communication in the hospital, and it was often the wives who gained most from it. Mrs. Fraser knew her G.P. well because he had looked after her and the children, and she felt that she could talk to him, while, at the hospital, she "didn't like to ask questions." Mrs. Langton had tried to get information from the hospital without success; but, by making a special appointment with her G.P., felt that she found out what she needed to know. Both Mr. and Mrs. Keoghan appreciated their G.P. "because she will listen and explain things." It is interesting that while the G.P.s presented essentially the same contradictions as did the hospital doctors (which will be discussed below) and sometimes unintentionally increased the contradiction by operating on a different model, yet these contacts were found by most people to be helpful. Some of the reasons for this can be surmised as; a knowledge of and recognition of the family as a unit, a greater willingness to be specific and greater individualisations.

In discussing the G.P. - patient relationship in dyadic terms, and the hospital doctor - G.P. - patient interaction in triadic terms, recognition must be given to Bloom's (1966) criticism of these concepts. He insists that the transactions between each must be viewed within the social context which influences each party and also the wider social context which shapes the system within which they are each embraced. Since this cultural view of the patients' experiences forms a central theme of this thesis and also as the cultural context of medical practice is not being treated as a central theme, Bloom's point is acknowledged and will be subsumed in the following discussion, without being further elaborated. The triad meant for the patient that he had dual-doctoring, from the G.P. to whom he felt closer, and from the hospital doctor on whose expertise he had learnt to depend. Mr. Hewitt's comment quoted above summarises the usual resolution of this

potential tension; both the G.P. and he were subject to the higher authority of the hospital doctor. The hospital would continue to make the major decisions which the patient and G.P. would implement in collaboration. In referring back to the Szasz and Hollender (1956) model of doctor/patient relationships that was discussed in chapter 3, a further elaboration of this model can be proposed here. This suggests that the two doctors achieved co-operation rather than conflict in their efforts because they implemented different types of relationship within a system of hierarchy. Most of the hospital doctors worked on a Guidance - co-operation level which consolidated the authority of their position. To quote in recapitulation, "The patient is expected to respect and obey the doctor". The G.P.s increasingly moved towards the Mutual Participation type of interaction, in which he and his patient were 'in it together', and both were constrained by the pronouncements of the hospital doctor.

b) The hospital doctors.

Two factors came together to reinforce the high status with which the hospital doctor continued to be endowed. The patients had learnt to depend on him and still experienced sufficient uncertainty and sense of threat for this dependance to continue. Secondly, their attitude was perceived to be supported by the attitudes of their G.P. Although out-patient appointments were infrequent, the patients saw them as being highly significant, as landmarks would be in a desert, confirming their sense of direction and that they were still on the right path. They used them to obtain further definitions of their health status and to confirm and legitimise further progress. Where these functions coincided with the ways that they were using their G.P.s, the hospital doctor's view was given the greater weight.

The phrases that recurred when the patients were anticipating their next appointment were comments such as "I think I might get to know something then" and "I'll see what the specialist has to say - I might be able to do things then." These were expressions of their expectation that the doctor would make definitive statements which would resolve uncertainty. In order to evaluate the extent to which they felt that their expectations were met,

it is necessary to distinguish between the status and the progress elements. In the realm of progress, they sometimes received specific indicators - they could begin driving again, they could increase the distance they walked, they could return to work - the kinds of decisions to which they had learnt while in hospital to attribute significance in defining their health. But over their health status in direct terms, they were often little the wiser. Such clarification as they gained, they had to infer from the fact that "the doctor was pleased with me."

Along the same lines, their final discharge from the out-patient department was given significance as marking the end of their illness as far as the hospital was concerned. Statements such as "I must be making good progress" or "They said 'You're too fit for us'" were common, although the message received was sometimes more guarded; Mr. Hewitt was discharged "unless I have more trouble." This definition of the end of the episode which was given by the hospital will be referred to again in a later chapter, in relation to other ways by which the end was marked. Only two patients had not been finally discharged by the time that the research contact with them ended. Both of them accepted this - Mr. Keoghane supposed "it was necessary" and Mr. Langton said "there was no need for me to go back for another twelve months" - but it was also confusing, Mr. Langton, for instance, had been told by the same consultant that "after a period of convalescence he was going to be perfectly normal." If this was so, he was justified in wondering why he needed an appointment in a year's time.

The patients' continuing dilemma about their health status both during the convalescent period and at the end of it was thus unintentionally increased by the dual messages from the doctors. They wished to reassure him and build up his confidence that he would not have a recurrence, that he was cured, yet at the same time they tried to persuade him to adopt the kind of behaviour that would reduce the risk of a recurrence, thus conveying that all was not completely well and that a recurrence was a possibility. Some further discussion of this, introducing the additional perspective of the post-illness health status, is appropriate.

While deviance theory is not been used as a concept that is central to this thesis, it has a contribution to make in this context. Freidson (1966) discusses the deviance of disability and stresses the importance of the "lay and official 'normals' who label deviance and carve out a role for it." He suggests that the role that is defined is influenced by: 1. Diagnosis the believed cause and amount of personal responsibility that is imputed. 2. Prognosis, whether it is curable, incurable or "improvable but incurable" and 3. Stigma. By relating these categories to each other, different types of deviant roles can be examined, reflecting the expectations and attitudes of the labelling person. He sets out this diagram.

| <u>Imputed prognosis</u> | <u>Responsible</u> | | <u>Not responsible</u> | |
|--------------------------|--------------------|--------|------------------------|--------|
| | No stigma | Stigma | Not stigma | Stigma |
| Curable | | | A | |
| Improvable | | | B | |
| Incurable | | C | | |

DIAGRAM 16. Freidson's diagram: Types of Deviance in Disability.

Although Freidson suggests this form of analysis for comparing different forms of deviance, for the present purposes, it is useful as a way of highlighting the confusion about the nature of the patients' deviant role.

The doctors' comments to their patients that they were "cured" "better than before", or "O.K.", would all seem to imply that they were operating on a concept of transient deviance which, after a period of time and by following their instructions, the patients would put behind them and "forget about it." This instance is marked as "A". However, their other comments to the same patients would seem to imply that they were really operating at point "B" above - by saying "normal but steady" "take it easy" "slow down" or "O.K. but watch your activity", they were indicating that the condition had improved, but that some abnormality, or deviance, would continue. This, in terms of the role understood by the patient, was a very different thing. In addition to this level of confusion, the doctors' stress on the importance of new health behaviour (weight loss and not smoking etc.) can be interpreted as yet another type of role in which the condition itself is not considered to

be cured but can be controlled by their own efforts. A relapse, then, would indicate that the patient has not conformed to the regime so that they become responsible for the next illness which will carry greater stigma. This stance echoes the attitudes of Mair and Harnett (1962) that were referred to in chapter 2. It is marked as "C" above. Of the patients followed for the full series of interviews, almost all indicated that they had some uncertainty as to whether their doctor really saw them at point A, B or C. In the light of the importance with which the patients endowed the doctors' defining status, Fraidson's words take on a heightened significance - "The individual is someone to whom something happens, who is then labelled by others and pressed to behave in a particular expected way quite independently of his own motives or desires. His motives may be involved in whether he rebels against the labelling, whether he falls into invalidism, or whether he becomes a show-case model of conformity to expectations, but the permanence and shape of the role he plays so badly or so well stand quite apart from his inclinations....His motives may determine how he performs in that role, but not whether he is placed in that role" (p.61). For these patients, the very role was ambiguous.

While this interpretation of a type of deviance element in the model that the doctors were presenting seems to offer a way of understanding the source of the patients' confusions, it was obviously not the way in which they usually expressed it themselves. Mr. Jessop seemed to see the dilemma for what it was. In the interview soon after his discharge from hospital, he talked around it "You don't know if you're cured or not - the doctor said 'You're not an invalid' and in the same breath 'You can't be a panel beater any more'. This tells me you ain't the bloke you was before it happened - to what degree you're not an invalid, it's difficult to define. - It's a fact that you can't do the work you did before - that makes it to me that you just ain't the bloke that you was. (People) say 'Elev down - it's simple'. I don't know how simple it's going to be. - The fact I won't be able to play bowls - that's another thing that makes you into a semi-invalid - from my angle, not the doctor's. If I can't do the things I done before, I'm a

semi-invalid, aren't I?". Mr. Archer spoke in the same way, saying that if there were any restrictions on his activity it meant he wasn't completely well, and so reassurance that he was cured was useless. These two patients perceived the contradiction very clearly. They responded to it with confusion, some anger and a fragmentation of their own position. If the ideas with which they were presented were mutually exclusive and yet they had to grapple to contain the separate pieces, so as a result their self-definitions and their behaviour had to be fragmented. Many aspects of the apparently inconsistent behaviour of the patients can be traced back to the fact that at different times and in different circumstances they were responding to different parts of the doctors' messages.

While the two patients just quoted could both conceptualise the dilemma for what it was, other patients expressed essentially the same confusion in terms of more immediate and practical issues. They spoke of their confusion about the amount of exercise they should be taking, about the rigidity of the diet, and about the different attitudes of different doctors. While each of these may well have been a real issue in itself, the real significance would seem to be that they were picking up covert messages from the doctor which qualified the overt message that he thought he was conveying.

Summary.

While the patients remained very dependent on their doctors' opinions as the prime sources of definitions about their health and progress, two additional factors were added during the convalescent period. Firstly, they became as concerned about their future health as about their present health status. Secondly, because they had dual-doctoring, the possibility of contradiction between the two doctors was added to the contradictions within any one doctor's statements. Although the view expressed by each doctor seemed to himself to be intelligible, when it is viewed in terms of deviant roles, it is found to be contradictory. These contradictions contribute to an understanding of why the patients were so confused and had great difficulty in implementing the advice.

II. The 'Cardiac Wise' Model of Convalescence.

Following their discharge from hospital, the patients rapidly experienced two developments. Firstly, the range of behavioural options open to them increased and they became more autonomous in the choices that they could make, with resultant increasing uncertainty. Secondly, and at the same time, they were exposed to an increasing variety of influences, each seeking to set forward their own model for his convalescent behaviour. This section and the next one, which will consider the models presented by 'others', are essentially very close, and are differentiated by the fact that the 'wise' were known to have experienced cardiac illness, whereas the 'others' did not necessarily claim any special knowledge. One other difference between the two groups was that 'others' were referred to by the patients when there had actually been some interaction with them, while the 'wise' were discussed as representing a type of the cardiac culture, whether or not the patients had been in recent contact with them.

Reference has been made earlier to the significance of the 'cardiac wise', as definers of the model of cardiac convalescence, developing from questioning why the patients so frequently and spontaneously referred to other heart sufferers that they knew. The analysis of their comments revealed that they were either positively or negatively identifying with the way that these other patients had coped with their heart conditions and the type of cardiac culture that they presented. By means of this positive or negative identification, the research patients sought to clarify their own position.

Considering first the ^{ways} ~~ways~~ in which they used negative identification, the concept of role distance would seem at first sight to have a high degree of relevance. However, on closer examination, neither Coser's (1966) nor Goffman's (1961 ^b) use of the concept adequately explains the patients' behaviour. When Goffman writes of role distance, "the individual is actually denying not the role, but the virtual self that is implied in the role for all accepting performers" and that it "refers to those behaviours that are seen by ~~someone~~ present as relevant to assessing the actor's attachment to his particular role and relevant in such a way as to suggest that the actor

possibly has some disaffection from and resistance against the role" (p.316) he is highlighting the aspect of identification. Coser however, criticises Goffman for not differentiating role from status and tasks, and also because she maintains that appropriate role distance is normative, the absence of it indicating either fanaticism or cynicism. She argues the case for speaking of status distance rather than role distance, which occurs with "the transition from one status position to another, and serves to resolve the sociological ambivalence derived from two roles, the old one and the new one" (p.332). In the context of this examination of the patients' experiences, though, the very absence of a consensus about status position and normative behaviour was a central problem for them. This lack of consensus and norms highlights the individuality of their behaviour. Each person's personally preferred behaviour and corresponding criticism of other people's behavioural choices must be seen in the context of the status identification or distance being held by both parties, that is, the patient and the 'wise'.

In this view, the patients were attempting to separate themselves from the way of acting out the cardiac convalescent status and its associated roles that they perceived that the wise were performing. In the situation of contradictory expectations about their status position along the continuum from the ill status to the well status, they implicitly rejected the way the wise had defined their status by criticising their behaviour. In justifying to themselves that their own behaviour was "sensible", they sought to establish it as normative, and in their criticism of the wise therefore placed them (i.e. the wise) in role distance from their own norm. This reversal of the actors would seem to make some sense of the concept, which like some others, cannot just be imposed on empirical data without some qualification.

There were three main forms in which the patients operated role distance, used in this sense. Firstly, and by far the most frequent use of it can be seen in the patients' comments on the model of the 'cardiac life' on which they ^(the 'wise') seemed to be operating. In doing this, they were

critical of both extremes of the Invalidity - Recklessness continuum. By rejecting these extreme models, they reassured themselves that their own path was well-balanced and "sensible". Mr. Easton after describing the care with which he was monitoring his own increasing activity, said "It depends on how you are - you might get someone who thinks 'Oh I daren't do that' and you might get someone else who thinks 'Oh, they've let me out and I'm fit - I'll run upstairs and see if it does me any harm'". Whereas he was rejecting both extremes at the same time, most patients concentrated their criticism on one or the other. Both forms merit separate discussion.

Those that rejected the 'reckless' model were on the whole either very anxious about their health or very uncertain about how well they were. Mr. Gould's words were "I know a man at work - younger than me, who has gone on just the same and done the opposite of everything the doctor has told him. 'Life's not worth living' he says 'if I can't do this, or have my pint, or.... To me, that's foolish - if you've got a family, you must do as the doctor says....when you're young you've got to take care of yourself." His father-in-law had also had a heart attack and "He doesn't do as he's told. He says to me 'You're 43 and you look after yourself - I'm 63 and I'm too old to change my ways - if I die, I die'. In a way it's courage, but I don't know if I'll adopt that attitude when I'm 63." Mr. Gould also rejected the attitude held by a neighbour - "A chap up the road said to me 'You want to get on with the business of living - don't think I don't know, I've had three heart attacks and I carry tablets'....He said it's out of his mind now, but I don't see how he can say that if he's carrying tablets around regular - how can it be out of his mind if he has to take them." Mr. Jessop, who decided to stop playing bowls, said of a friend who was continuing playing "That was his second....he's adopted the attitude, if it's going to come, it'll come. My attitude is, I don't want to do anything to help it." Mr. Hewitt, who didn't know how soon he should expect to return to work spoke of "a man who went back to work too soon and was out again after two or three weeks - same trouble as me."

The criticisms of invalidity were just as real to other patients. Mr. Fraser was one who wanted to stress his intention to return to full activity again. Like Mr. Jessop he belonged to a bowls club, but a different one, but he had resumed playing. He said "two or three at the club have had heart attacks, but they don't play - they sit there and think about their illness and talk about it and wonder whether they should take their pills.... The other players say they should be like me....I don't let myself get like that," and a few minutes later in the same interview, "Those men, they're no worse than me but they make themselves worse by their routine. Their mental approach is wrong. They're no older than me, or I'd understand it." Medication, again, featured for some of the patients. Mr. Easton, who did not need to continue to take tablets, talked of "a man, who after his heart attack had to continue to take tablets and thought he was an invalid for the rest of his life. I said 'Nothing of the sort. If your blood does need thinning down, you've just got to live with them and take them - Surely it's better than not having them or being ignored.' He'd gone the other way - the fact that he'd been told he'd got to take them for some time, and he was an invalid for life as far as he was concerned - Wrecked." Similarly, Mr. Langton who, in the early days of his convalescence thought it better not to take tablets if he could avoid it, was critical of a friend who "takes them like peanuts. If he walks down the garden, he has a tablet. I don't particularly want to get to that stage with them." It is interesting to notice that in his case, after the doctor had recommended him to take more tablets, he began to use them very much like the friend he had criticised, and he then spoke of his friend with positive rather than negative identification. Mr. Keale was bothered by friends who said that from their experience, one "never got over it", but although his confidence was shaken, he rejected their view. By establishing role distance from these models, these patients were justifying and confirming their own choice of behaviour.

Secondly, they sometimes tried to justify the role distance by drawing attention to some characteristic of the wise which made their different behaviour more intelligible. On some occasions, they suggested that the

other person had had a more, or a less, serious heart attack than they had had. Mr. Hewitt met a 'wise' friend who had been off work for six months and who took a lot of tablets. He himself was sure that he could return to work early, and so he distinguished himself from his friend, saying "His must have been a serious heart attack." On other occasions, the patients differentiated over the question of the age of their 'wise' friend - because he was either older or younger than they were, his behaviour might be expected to be different. The device of finding rational reasons for the distance between themselves and the 'wise', again meant that their model was not a threat to the one on which they themselves were operating.

The third form of distinguishing between themselves and the wise concerned the eventual outcome of the illness, particularly in cases where they had known of someone who had died as a result of the heart attack. They offered reasons which they felt explained the death, such as that they were old anyhow, or they had been over-exerting themselves, which, because they did not apply to themselves, need not at least consciously increase their anxiety.

There were fewer examples of positive identification with the 'cardiac wise' than there were negative ones. These were again mainly among the anxious or the uncertain who wanted to compare themselves with others to reassure themselves. Mr. Dodds, after talking of his concern about his continuing chest pain, spoke of an ex-colleague who had had three heart attacks and "had learnt to cope and not worry too much." Mr. Mears who also had episodes of pain, considered that he was better than a friend of his as he could walk further than he could. When Mr. and Mrs. Keeghan were arguing about whether he should return to his job as a welder; (she thought it was too strenuous and he did not think so) he quoted colleagues - "Other people have had the same thing and they've gone back on the same job and they haven't suffered anything."

In these ways, whether the model presented by the 'cardiac wise' was viewed positively or negatively, the use that they were making of it was essentially the same. They were trying to clarify the issues which seemed

so confusing to them and to confirm to themselves and others that the way that they were performing was the right and best one.

III. The 'Others' Model of Convalescence.

The 'others' claimed no expert knowledge nor experience of cardiac illness, nor were they imputed to have any by the respondents. They were, however, on the whole interested and caring. Several patients said that they could not understand how so many people knew that they had been ill. They received messages and inquiries from people they hardly knew or had had no recent contact with. Within neighbourhoods and networks, information about his illness and progress seemed to be news-worthy enough to be passed from person to person.

One theme within these messages from others that was mentioned by only two patients but which seems of sufficient importance to discuss, was the worrying effect that their illness had had on their contemporaries, either as friends or colleagues. Sudden and threatening illness had become more real to them because someone they were close to had had it, and they were worried for their own health. Both Mr. Fraser and Mr. Easton were aware of this effect that they were having, and were amused when the 'others' began dieting or taking more exercise as forms of health-promoting behaviour. Neither of these men were especially anxious and gave no impression that this response to their illness caused them any concern. It is possible to speculate that, had they been more anxious, they might not have been able to perceive this attitude in the others.

The most usual theme in the ways that they interacted with the patients was to advise caution. Mr. Jessop said "They think you're dying." Mr. Easton, who had for a long time been heavily committed in Church work, found people expected him to do less - "If you're off sick for four months, they appreciate you're not off for nothing." In the same interview he said "Everyone you speak to 'It's nice to see you back on your feet - Now, you look after yourself, don't do....' If you listened to everything like that, you wouldn't do a thing." While some, such as Mr. Gould found this advice increased his own anxiety, Mr. Easton showed a remarkable ability to under-

stand the position the other was in - "I think everyone you talk to - It's the standard advice 'Watch you don't do too much....You mustn't do that.' What else can they say to you? They can't say 'Get on and do a bit more - you should be doing more than this by now.' So the standard thing to do is to say 'Come and sit down. Are you O.K.?' "

This perceptible comment highlights the difficult situation that the 'others' were in. If the patient and his wife were themselves uncertain about his health, and were likely to be conveying this even if unintentionally the 'others', being yet further removed from sources of definition must have been more uncertain still. They were therefore dependent on common-wisdom notions about heart disease, which within Western society, are largely based on a recognition of the threat to life which it contains. Not knowing how severe the illness had been for the individual patient and probably being more familiar with the prolonged-rest form of treatment that was usually prescribed until recently, their message of caution is an understandable response. Montaire's (1973) study on behavioural expectations for the cardiac forms an interesting comparison with this. His study set out to investigate the observation that cardiac rehabilitation was often blocked "because the patient, or others who influence him, hold an opposite view (from the doctors) about the efficacy of activity for the cardiac, and cardiacs report that other people expect them to be inactive and 'take it easy'". His survey demonstrated that "other people" whether or not they knew anyone who had had a heart attack were more likely to think that activity was beneficial to the cardiac patient than were cardiac patients themselves. He does not attempt to resolve the apparent contradiction in his findings between the statement above and his other finding that "Ninety per cent of the cardiacs studied....said that people did not expect them to be active, and that furthermore others believed that activity might precipitate another attack." If one assumes that both of these findings are reliable, and the second is certainly in harmony with the present study, it would seem to be important to discover whether some other variable influenced the discrepancy between the 'others' reported beliefs and the

behaviour of such 'others' as the cardiacs experienced it. It has already been noted that in the present study the 'others' all had face-to-face contact with the patients. They did not therefore have to hypothesise about their favoured behaviour not draw on memory of an earlier event which had subsequently been reinterpreted. They were face-to-face with someone they knew who had recently had a cardiac illness, and for whom they did not know the extent of his recovery. It is therefore suggested that the attitudes that Monteiore states that most people claim to hold may break down in a reality situation in which they are aware of their own uncertainties, so that the way they behave towards a cardiac convalescent is different from the way they say they would behave.

While the uniformity of this advice was taken by the patients and their wives as well-intentioned, but lacking in authority, it still had some significance in their search for a pattern for the convalescent path. In as far as the attitudes presented by the 'others' ^{were} culturally determined, the husbands and wives had been socialised into an essentially similar set of responses, and some of their own ideas were thereby supported. Although the 'others' were likely to propound a version of the desirable 'middle path' that was nearer the Invalidity end of the continuum of possible behaviour than was the view even of the wives, they all shared a concern that by taking care he should avoid a further crisis. That is to say, they counselled caution and the less active range of behaviours.

While most of this counsel^l was in harmony with the families', and especially the wives' views, there were times when it struck a discordant note. This happened when either one 'other' spoke out of tune with the rest - such as Mr. Hewitt's friend who advised him to "keep on the move" while everyone else told him to rest - or when the 'others' were strikingly out of harmony with other and more influential units of the role-set. This latter point needs further elaboration. An instance of it occurred in the Langton family, who in their anxiety about getting the husband's regime "right", had sought to make specific the very vague medical instructions they had been given. On this principle, soon after his discharge from

hospital, he had started going for short walks - taking "measured rest and exercise" which they believed to be the correct stage of his recovery. The neighbours who saw him were "appalled - my next door neighbour said 'Oh, I wouldn't let him do a thing'. I had to say 'This is part of his treatment'. It seems to me it's a relatively new thing - I hope we're not guineapigs." This illustrates not only the discord between the neighbours' model and what they believed to be the medical model, but the anxiety that this tension aroused. While part of the discrepancy could be explained away by implying that the neighbour's concepts were out-of-date, even that raised questions about the amount of confidence that they should invest in the doctor's opinion.

A completely different form of discord occurred occasionally when the 'others' assumed that the husbands' recovery was completed more quickly than either they or their wives thought. As did the hospital doctors, they identified an end to the incident which did not always coincide with the families' perceptions. This response was a subsequent development of the Langtons' interaction with their neighbours which has just been outlined. A month after this incident was reported, his wife expressed her concern - "He looks so fit, some people expect him to be back in harness. He is fit - he does the garden and cleans the car etc....People over-estimate what he can do and he under-emphasises his condition - he always minimises things." He picked up the conversation "People have seen me doing things and have tended to think 'Well, he can't be as bad as he thought he was'. It's this different technique with these heart troubles." The 'people' referred to were mainly the same neighbours who had earlier urged greater caution. This illustrates a very interesting aspect of disharmony; the neighbours had at first assumed that his condition was serious and so thought his exercise was Reckless. They had later revised their view of the severity of his illness because of the way he was behaving, which seemed to be confirmed by his "under-emphasis." In the light of their new interpretation, his continuing caution was seen as inappropriate Invalidity behaviour. Again, their concern was for him to find the 'middle path', but their interpretation

of it was greatly at variance from the Langtons'.

Some found that they were almost embarrassed by looking so well and yet being off sick. When Mr. Hewitt went out for walks during normal working hours, he found that he wanted to explain to people he met that he was genuinely convalescing, as he felt that his looks belied him. He wanted them to know his position rather than risk their thinking that he was taking time off illegitimately, which he expected them to think because his appearance was so healthy.

'Others' in the work situation.

When the patients returned to work, they were almost all treated with some degree of concern by their employers. Mr. Neale was offered help with the heavy lifting in the stores. Mr. Jessop and Mr. Easton were advised to adjust their hours to suit themselves or avoid rush-hour travelling. Mr. Fraser and Mr. Mears were expected to "do less." While some, such as Mr. Easton and Mr. Keeghan, thought they were unnecessarily overprotected, most of them appreciated the opportunity to "ease themselves back in" and found the privileges acceptable, even if they were only for a short time. They viewed them as a demonstration of concern and as intended to be of help, even if this was sometimes mis-placed. The exception to this practice was Mr. Hewitt, against whom there seemed to be discrimination. Although his Industrial Health staff and his shop steward had agreed that he should have a lighter job and be protected from pressures, Mr. Hewitt himself thought that his work-mates resented his privileges. He found the atmosphere very unpleasant and experienced the situation as a further expression of the ambiguity of his health status.

In summary, the 'others' who interacted with the patients were seeking to influence them to conform to their concept of the way that a cardiac convalescent should behave. Their model was usually based on the assumption that he had had a severe heart attack and that some degree of invalidity was appropriate. In formulating this, they were relating common-sense notions about cardiac behaviour to the desire for a known patient to employ caution. However, when the signs of severe illness that they expected to see

were not demonstrated, they might change their attitude from advising caution to imputing malingering.

IV. Summary of Chapter.

Of the three units of the role-set which have been discussed, the medical not only assumed, but was also imputed to have the greatest authority. The 'wise' and the 'others' who drew on experience or common-wisdom, may have intended to reinforce this medical authority, but their models were often greatly at variance. While no definitive weightings can be given to each of these influences, different levels of their use can be identified. The patients took the medical model as an ideal, and as far as they could understand it and implement it, tried to make it their own. At the second level, the 'wise' and the 'others' models were used to reinforce their own personal interpretations of the medical model. Similar processes will be seen in the next chapter which discusses the wives' model.

6. THE WIVES' MODEL FOR THEIR HUSBANDS' CONVALESCENCE.

Although the wives are conceptualised as a member of the patients' role-set, their model of convalescence is now separated into a chapter on its own because there is a disproportionate amount of material on it, due to the fact that they were taking part in the interviews. While it is true that they were also interviewed during the hospital phase, their experience then was so closely linked with the setting of the institution that a combined analysis was appropriate, in chapter 3. The present chapter conveys their experience and their views of their husbands' convalescence - a reality which was in some ways a continuation and in some ways a contrast from their earlier predictions. Although it has been suggested that the medical model of convalescence was taken to be the primary one, the wives were the members of the role-set most able to exert regular influence over their husbands' choices within the range of behavioural options open to them, (as discussed in chapter 4). This was due, in practical terms, to the fact that there was constant interaction between them. The husbands, often for the first time in the marriage were at home all day, and during the early stages of their convalescence were not leaving the house at all. In addition to this structural change, the wives had high investment in ensuring that their influence was effective, as they perceived that a 'successful' convalescence was a way of averting a repetition of the crisis.

I. The Grounds of the Wives' Performance.

Most wives expressed considerable confidence in the model of convalescence which they individually defined for their husbands. In view of the general atmosphere of uncertainty, this seems rather surprising, and possible reasons for this certainty cannot be suggested with any great confidence. They were subject to the varying and contradictory influences from essentially the same role-set as their husbands were, although some differences between the two role-sets and variation in the amount of influence attributed to different parts must be expected. However, unlike the other influences, their role was one in which they had some degree of control over their husbands. Unlike other units of the role-set, they did not just present a

model and withdraw; by being constantly present, they had available to them a range of devices and strategies by which they could make the model operational. The other resource on which they frequently drew to confirm the model they held, was their own experience of recovery from illness. It has been noted (in chapter 3) that in the early stages of the illness, the wives used their own experience to help them to understand their husbands' situation, and also that at that period it was easier for each spouse to understand and imagine the role of the other. During the convalescent period, however, this use of their own experience became a source of stress. Because it was a major ingredient of their conception of the way that convalescence should proceed, it was difficult for them to see their husbands proceeding by a different path and not to feel critical of them for this. Mrs. Archer, for instance, became very angry with her husband when he expressed his continuous anxiety that the heart attack would recur. She said - "When I had asthma four years ago, and I used to say I don't think I could go through that again, you used to say 'But look, you might never have it any more' and that's quite true, and tough wood, I've never had another attack again. Dr. W. said I might never have it again, or I might have it for the rest of my life. But I took it that there's a chance I might never have it again, and that's what I worked on. It really did frighten me - and many times you've said to me 'Look, it's not necessary for you to have another attack - you'll probably never have another one'. I could have gone on for years thinking 'What if I have another one'". The interaction between them was very highly charged with anger; he tried to distinguish his situation from the one she had experienced and she insisted that they were parallel and that he ought to be behaving as she had done. Mrs. Keoghan, also had used her experience of illness with empathy in the early stages, but became impatient with her husband's depression when his convalescent improvement seemed to him to be so slow. It was only when she was reminded that she also had experienced a similar phase of depression that she became less critical of his attitudes. At this stage, therefore, the wives who had experienced illness had some certainty about the process of convalescence as they had

passed through it, but they were then under stress when they found that their husbands' interpretation of the passage was different.

The main exception to this general experience of confidence was Mrs. Langton. In order to understand her view, it is necessary to develop the distinction that was drawn in chapter 3 between being confident that the role of the wife was of central importance and being confident in how to execute it. Mrs. Langton was completely convinced that her role was crucial to her husband's recovery - "Because the doctor said to me - this is one thing he said to me the first time - the lack of progress if the fault of the wives because they just watch them and don't let them do things." Although she felt that the doctor had communicated with her far less than she wanted or needed, the one thing that she had gathered was that the way she behaved towards her husband would influence his recovery, but that this might be harmful. As to how the behaviour of each of them should be seen, she was at a complete loss. In talking of her need for "guidelines" and information, she said, hypothetically, "Once you know, it relieves you completely. You sort of know what you've got to do." At the end of the convalescent period, she looked back over it - "What annoys me is that I didn't give him confidence. This is ever so important. If I had felt confident in myself - if the doctors had said 'Face it, he's going to be so-and-so and this could happen; encourage him to take his tablets.' If they had only said that one thing - that would have made a vital difference to the last five months." To know that her role in relation to her husband's convalescence was important and then not to know how to perform it, caused her terrible anxiety at the time, and left her with self-reproach afterwards that she had "held him back."

II. The Wives' Attitudes towards their Husbands' Behaviour.

Two themes run through much of what the wives said about the ways that their husbands were seeing and performing in their situations. The first of these conveys a quality of moral judgement, such as a parent might make on a child's behaviour, and concerned whether their husband was "being good." The second reflected the wives' continuing concern about ways by which a

recurrence of the illness could be avoided.

In commenting that their husbands were "being good" or "being sensible", the wives were lacking an authoritative blue-print as to what their husband's behaviour should ideally be, but felt able to pass a moral judgement on it. This apparent anomaly can best be understood in terms of the extent of the 'fit' between her prescription of the role he should be playing and the role that he perceived for himself. Rapoport and Rosow (1957), in a study of male patients under psychiatric care, introduced the concept of "the fit between the norms of the patient and others about his proper role performance" as one of the ways of understanding the stress within families. When this perception was fully shared, both spouses felt that their reciprocal roles were satisfactory. But a further element has to be introduced into this when considering the interaction between husbands and wives. This occurred when the wives said their husbands were "being good", but the husbands had unwillingly agreed to a role that they thought inappropriate. In Goode's (1960) sense, he was tolerating 'role strain' in exchange for approval. The Easton family typified the possibility of real consensus; the Fraser family that of consensus achieved at the cost of 'strain' - she said "he is being good", he said "I could be doing more." Thomas's (1966) concept of 'role synchrony' is also useful in developing this analysis as to why the wives judged their husbands' behaviour as "good." Writing in the context of permanently disabling conditions, Thomas proposes that a 'disabled self' has options open to him of performing handicapped behaviours and non-handicapped behaviours, either of which may be correct or incorrect in the light of his physical state. 'Non-disabled others' can behave towards him choosing between 'behaviours appropriate for a handicapped self' and 'behaviours appropriate for a normal self'. He sets it out in the following diagram.

Behavioural options
of Self.

Behavioural options of others.

Behaviours appropriate
for a handicapped Self.

Behaviours appropriate
for a normal Self.

Handicapped behaviours

Correct for Self

1. True handicap

2. Imposed normalcy

Incorrect for Self

3. Fictionalised
handicap

4. Antistio handicap

Non-handicapped
behaviours

Correct for Self

5. Imposed handicap

6. True normalcy

Incorrect for Self

7. Antistio normalcy

8. Fictionalised
normalcy

Diagram 17. Thomas' Diagram.

Varieties of synchrony of repertoires of role behaviour for Self and Others.

While this scheme assumes some criteria for distinguishing 'correct' from 'incorrect', in the present context, this can be taken as 'believed to be correct/incorrect' as the focus is essentially on perceptions. Full role synchrony exists when both parties agree to either true handicap or the True Normalcy - the husband will not mow the lawn, but he will continue to read the children a story at bed-time. Strained role synchrony is featured as both Fictionalised handicap and Fictionalised normalcy. These were both very rare within the present study, as the wives expressed no feelings that their husbands were inventing or exaggerating their disabilities, except possibly in the sphere of anxiety. Fictionalised normalcy really requires that there are some objective criteria against which the behaviour can be assessed, although there was one instance in which it could still be applied to perception. Mr. Gould illustrated this; soon after his discharge, there was to be a family wedding to which they had been invited. He did not feel well enough to go and was worried when his wife suggested that he should be able to do so. In weighing the relative disadvantages of attending the wedding and being left alone at home, he decided he would go to the wedding, and so 'fictionalised normalcy'.

The most common form of role asynchrony that was demonstrated in these families was 'imposed handicap', in which the wife treated the husband as though he was handicapped in some behaviour while he thought that he could perform that behaviour normally. Illustrations of this will recur throughout the following discussion, but to give just one - Mrs. Hewitt had established a rule that her husband should not have a bath while he was alone in the flat "in case something happened"; he thought that this was an unnecessary restriction and agreed to keep it very unwillingly.

The moral judgement element in these views is linked with the mothering role that many wives assumed, in which they treated their husbands as though they were children to be guided and protected and whose behaviour could be evaluated. It is almost impossible to disentangle the extent to which they were imposing this continued regression (see Lederer 1952), onto their husbands from the extent that they were responding to expressions of regression that they identified within his behaviour. In the most extreme instances, such as Mrs. Archer who stopped regarding her husband as a peer and related to him as a child/oldman, the role strain that he experienced would indicate that it was imposed regression. But most cases were more ambiguous - Mr. Fraser enjoyed having a fuss made of him and "being spoilt" but at the same time got angry if he felt that his wife took it too far. This attitude of mothering will be seen to underlie many of the roles that the wives assumed.

The second theme which ran through the wives' view of their husbands' behaviour concerned the ways by which a recurrence of the illness could be avoided. Most of the wives who spoke of their own anxiety about the possibility of the illness recurring, also thought that their husbands could and should take steps to avoid it. Their anxiety about his future health gave added investment to their concern about his present performance. "Being patient", "Getting it right", "If he behaves himself", "That's why the diet is important" were all related, as exhortations for the present, to the goal of avoiding a repetition of the illness. While most of the wives tried to stop their husbands worrying about their health, and discouraged them from talking about it, the subject was acceptable to them in the context of influencing his

behaviour to conform to their model - it was a threat that he could avert by doing as he was told. The contradictions within their attitudes will be referred to again later, but it needs to be noted at this point that the contradictions were strong over this issue. They also echoed the contradictions that were shown to be present in the attitudes of the hospital and medical staff.

Mr. and Mrs. Hewitt were unusual in their ability to be able to admit their on-going worry to each other. In looking back over his illness, he said "I'll never forget it", which she picked up, going on to say "It doesn't seem long ago - the time's gone very quick - it's not something you get over very quickly....It's something you don't really get better from - you know there's always going to be a weakness there. You don't recover completely. This is what you live with....I watch him and keep an eye on him - when he tries to do too much, which he does, I try to stop him a bit.... You're waiting for things to happen all the time." Mrs. Keoghan was more usual in making her comments when her husband was out of the room - "I'm still concerned, but I don't show it when he's there....It'll always be at the back of my mind - wondering, is he going to have another attack. I don't think I'll ever forget it could happen again - it'll always be there." Both these wives thought that their husbands could actively reduce their chances of having a recurrence by "doing as he's told", and their anxiety made them more insistent that he should conform to their regulations.

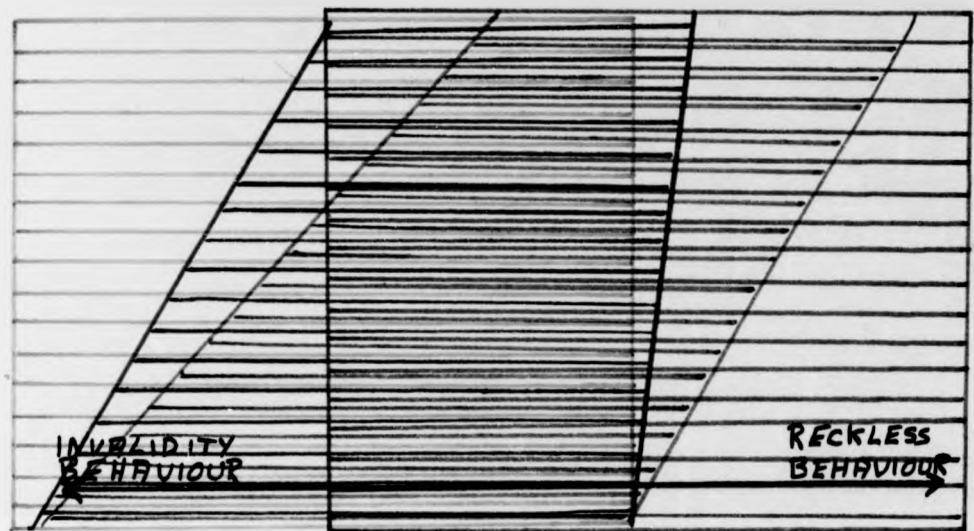
While not every wife spoke so clearly about her fear of recurrence, this attitude can be inferred from the comments and actions of most wives. In terms of the roles that they played in order to influence their husbands' behaviour, there was no difference between those who put it into words and those who implied it. The only exception to this were two wives whose primary chosen role was that of Normaliser, which will be discussed below.

III. The Wives' Expectations of their Husbands' Behaviour.

It has already been noted, that once the husbands left hospital, the range of behavioural options open to them widened rapidly. In a sense they were in a position to resume most of their previous activities that they were

physically capable of managing. Out of all the choices open to them, their choices were constantly being influenced by the opinions of others. It has already been said that the wives saw themselves as a major influence, and generally the husbands concurred with this.

Almost all wives wanted their husbands to take a 'middle path', avoiding extremes both of 'Recklessness' and of 'Invalidity'. In this, the husbands were generally in full agreement, although the actual nature of the 'middle path' was often seen differently by each spouse. Where this difference existed, the wives in nearly all cases tended towards the more cautious path. To refer again to the diagrammatic categorisation of activities that was proposed in chapter 4, the usual difference between the wives' and husbands' views of his appropriate behaviour may be presented as:

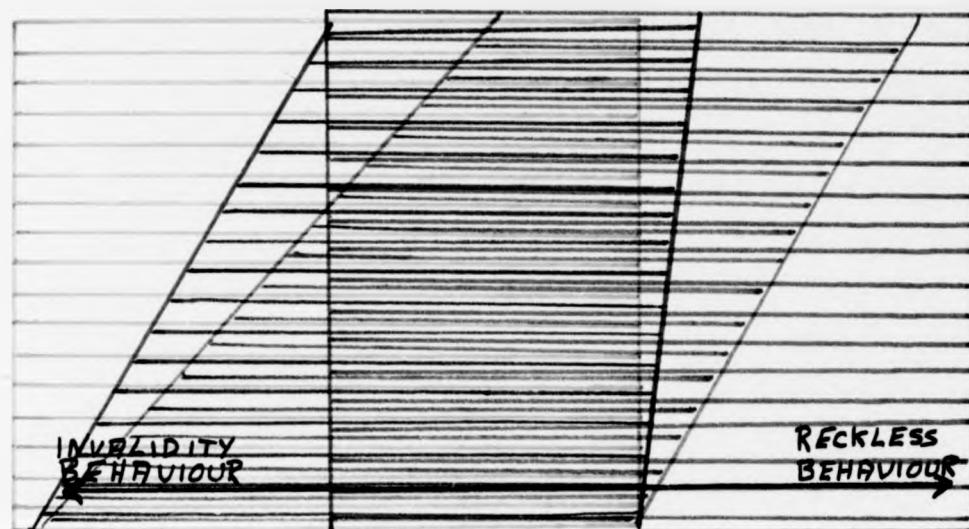


Wives' choice



Husbands' choice

Diagram 18. Wives and husbands' choices of behaviour.



Wives' choice



Husbands' choice

Diagram 18. Wives and husbands' choices of behavior.

It is interesting to notice that the wives who spoke critically, and sometimes with anger about their husbands' choice of behaviour, saw him as erring towards both extremes of behaviour. Mrs. Dodds, in the same interview, blamed her husband for wanting to attempt a strenuous task - "He thinks he can do more than he can", and also for being too concerned about the pain he was having - "he's too aware of the pain". Similarly, Mrs. Keoghan thought her husband was holding himself back because of his anxiety, but also criticised him trying to do more than he could manage.

Once again, contradictions are being shown to exist in within the model with which the husbands were presented. They weren't to do too much, but they mustn't do too little. When they got it right, in the sense that they conformed to their wives' expectations, they were commended for "being sensible." When their path was at variance, they were criticised and pressured towards conformity. But the dilemma and contradictions extended beyond the choice of approved activities, to include the way the wives presented their perception of their husbands' health status. In direct parallel with the mixed messages that were being received from the doctors about their present and future health, the wives were also trying to convey reassurance at the same time that they were imposing their restrictions. The confusion inherent in this reflects both the wives' own uncertainty about their husbands' health, but also their complete certainty that by whatever means were available to them, they must hold him to their perceived 'middle path'. Their contradictions take on a new light when seen in this context, in that they were responses to the fluctuations in their husbands' views. In this way, when they observed or heard their husbands say in an interview that they were increasing their activity, which the wives thought was straying towards 'recklessness', their response was to reinforce the boundaries which demarcated permitted from forbidden exertion. Similarly, when they thought their husbands were straying towards 'invalidity', they would respond with reassurance to push him back towards a central position. The husbands' responses to these pressures will be discussed in the next chapter.

IV. Roles Assumed by the Wives.

The devices used by the wives to promote their husbands' conformity can best be seen in the roles which they played in relation to him. The roles set out are not intended as a mutually exclusive set of categories, but rather as representing a repertoire from which they selected the role that they thought served their present purposes. In this context, it is necessary to refer again to the methodological problem that was noted in chapter 1, concerning the difficulty of obtaining a picture of pre-crisis family function when the study begins after the crisis event. Although many of the families talked of their pre-illness patterns, often giving very graphic pictures of these, it must be recognised that the information selected and the way in which it was offered was to some extent coloured by their new situation. Because the extent of this unintentional distortion cannot be assessed, any suggestions about the connections between pre- and post-crisis family patterns must be very tentative. The data would, however, suggest that, unless the crisis was being used by both spouses as an agent of change in a desired direction, (as in the case of the Mears family), the later patterns were a development and elaboration of the pre-crisis patterns. Mrs. Dodds had always 'managed' her husband; Mrs. Hewitt had always made decisions for her husband; Mr. and Mrs. Easton had long established habits of collaboration. These wives selected the majority of their roles towards their convalescent husbands from these sections of the possible repertoire. Not only did this 'ring true' for the personality of each spouse, but it also offered a degree of continuity to the pattern of 'role fit' that they had already established.

While this essential continuity is suggested tentatively, some confirmation of it can be found from the parallel study by P. Morris (1965) on prisoners' wives. In this more extensive study, she confirmed her preliminary hypothesis that "family relationships following upon conviction and imprisonment will follow a pattern set by family relationships which existed before imprisonment" (p.23).

The roles the wives played can be seen as an elaboration of the roles

they had predicted for themselves, which were outlined in chapter 3. They were:-

1. Activity-Manager.

Some forms of this were overt management. These can be divided into:-

a) Adoption of a hospital-substitute role. It was shown in chapter 3 that while the husbands were in hospital, the wives were content to allow the hospital to take over some of their roles, and saw themselves as reinforcing the staff's disciplining function. On his discharge, however, the hospital's day-to-day control ceased and this was inherited by the wives, who saw themselves as an extension to the hospital's influence. In order to implement this, they would continuously cite the doctors' instructions or, when these were non-specific, would seek to make them concrete and then hold these up as an authoritative model. In order to justify their interpretation of these non-specific instructions, they would find excuses for the doctors. Mrs. Jessop, for instance, in agreeing with her husband that he should not play bowls, said that if the doctor had known the amount of exertion involved he would have said this, but as he did not know enough about it to mention it, "One must use one's discretion." Mrs. Mears used the same ploy to reinforce her insistence that her husband should not carry the shopping bags - "sometimes the doctors don't remember to tell you simple things" - with the implication that if the doctor had thought of it, he would have agreed with her. Mrs. Hewitt was rather more critical - "the doctors don't want the responsibility of being specific" - which meant to her that she had to make the specific decisions on his behalf and could assume his authority for them.

In taking on themselves this disciplining function of the hospital and by upholding the doctors' authority, the wives became subject to the bargaining power of their husbands. The situation is similar to that discussed by Roth (1963 pps 108 and 49) who described the careers and timetables of treatment of T.B. patients. The doctors controlled the treatment programmes and length of hospitalisation for these patients, but were influenced to greater or lesser degrees by pressure from the patients to

modify or expedite this. One way of handling this pressure was to remove the authority to make decisions about granting concessions from the junior doctors who were in closest contact with the patients. While pointing out the problems that this policy created, Roth commented "this solution can be used only when the ward doctors are interneers or residents-in-training or unlicensed foreign physicians working under a restrictive contract." He is here suggesting that a 'lower grade worker' does not have sufficient authority to be able to withstand bargaining pressure in the same way that a senior doctor can. At another point, when again discussing the doctors' decisions to grant patients an earlier discharge date, he writes "Such readiness to accede to the patient's wishes often annoyed the nurses, who believed that the doctors should be 'more firm' in dealing with the patients." The parallels that are being suggested here are that the wives placed themselves in a position comparable to the interneers and the nurses, both of whom had limited authority of their own but were committed to upholding the consultants decisions. If the consultant seemed to be too strict or too lenient, he could be blamed and not them; so long as he held to a consistent policy, they could rest in his reflected authority. Roth's analysis offers a valuable insight into the extremely vulnerable position that the wives held. Having little acknowledged authority of their own, they invoked the doctors' authority as a means by which they could withstand the bargaining pressures from their husbands. Not only did they frequently remind their husbands of what the doctor had said, but when his instructions were too vague, they elaborated them with their own specific details and endowed these with a medical seal of approval.

Inheriting this hospital-substitute role gave several wives a period of acute anxiety when their husbands were first discharged from hospital. They felt unprepared for it and lacking in sufficient information about how well he really was. The story told by several was of creeping downstairs to where he was sleeping at intervals all through the first few nights to make sure that he was all right and was still breathing. The processes by which they gained their confidence to act as hospital-substitute are not at

all clear, but the development occurred very rapidly.

Those wives for whom this role was a major one in their repertoire had either been nurses or had had a period of serious illness themselves. It seems to be reasonable to assume that these experiences had influenced their tendency to identify with the medical model and reflect the doctors' authority. While it is recognised that these experiences might equally well have made them more sceptical, for these wives they seemed to have a positively identifying influence. Some aspects of this role will be seen to relate to the Ultimate Arbiter role discussed below.

b) Restrictor. Once the wives had decided which activities were permissible and which were forbidden, they then tried to keep their husbands to the allowed ones. In this overt form, their control was usually expressed in terms of "I won't let him...." The activities thus proscribed were thought to infringe medical instructions or else to hold some high element of threat because of the kind of exertion that they involved. Mr. Fraser, for instance, after he had resumed all his regular activities said "I want to roll the lawn with the roller, but she won't let me do that." Considering the other strenuous things he was doing, he found this exclusion an anomaly, but his wife insisted on it.

To implement this role, the wives had to be constantly vigilant. Mrs. Hewitt saw her husband stoop to pick up the grandchild who had run to greet him - "It frightened me to death. I shouted at him - "Don't pick him up'." Mrs. Easton denied that she controlled her husband, but when she felt it necessary, she would do so. He said - "She caught me going up stairs one day." She took up the ^{story} story - "He knew I was in the kitchen, and I just roared at him 'Where do you think you're going?' 'Upstairs' 'You're not'. I won." Mrs. Keoghan came back from work to find that her husband had hoovered the house - "I ticked him off about it, because I think that's a bit strenuous. I'd rather he didn't - I'd rather he left it for me to get on with. Of course I'm not always here to stop him. He even got the carpet sweeper out one morning....I got annoyed with him, and he got annoyed with me because I wouldn't let him do it." Mrs. Dodds also had a battle when she

found her husband trying to repair a shed that had been wind-damaged. As a part of the same discussion, he said "She won't even let me lift the blooming car bonnet to see if it needs any oil," she remarked "We've had a battle of up and down stairs - He's still restricted to once a day. He's sneaked up the odd time and I've had to get at him."

This exercise of control became the main focus of anger between husbands and wives. In some of the interchanges, there was an atmosphere of parent/rebellious adolescent in the way that they related. This seems to be clearly illustrated in the ways that several husbands said that they "sneaked around" her rules. Naturally, in the interviews they only admitted to this over instances when they had been "caught" by their wives, but the response occurred sufficiently often to lead one to suppose that they resorted to this quite often, and when they had "got away with it", they weren't going to admit it in the presence of their wives.

The chosen mode of enforcing their restrictions seemed again to reflect previous patterns of relationship. To quote just two of the more extreme examples to illustrate this; Mrs. Hewitt said "I natter at you a bit more than I used to....I keep on at him a bit and he gets a bit ratty." Mrs. Berry, in the context of a very strained marital relationship, tried to use threats - "I get angry and I said 'I'm not coming back - if you go against what you've been told'."

There were two forms of covert activity management -

c) Manipulator. When operating in this role, the wives tried to organise events so that their husbands would not find themselves in a situation which might be too strenuous. Visitors were spaced out so that he would not become tired, and if they stayed too long, their departure would be hastened. The wives ensured that heavy tasks such as carrying coal were completed before their husbands settled by the fire so that he would not feel tempted or required to do them. When doing joint activities, the wives would organise the task so that they undertook the strenuous parts of it. In these ways the wives tried to make their control less obvious, because by manipulating the situation, they avoided a situation of confrontation and having

to say openly "Don't." As a role, it was played frequently by wives who were trying to reassure their husbands about their recovery and therefore did not want to have to face them directly with restrictions. It was also used by wives who maintained that their primary role was that of Collaborator and for these, it was very closely linked with a Final Arbiter role.

d) Final Arbiter. The activity-management used in this role was carefully disguised and only resorted to when all else failed. It was usually not recognised by the actors, or only referred to obliquely. The implication of it was that wives would allow their husbands considerable autonomy in deciding their activities, while they would be Watchers or Collaborators, but if they thought that he had made a seriously wrong decision, they would then step in and insist that they should be allowed to over-rule. Mr. Irwin, immediately after saying that he intended to make his own decisions about his activity, said "She'll just stop me I suppose if she thinks I'm over-doing it....I'll have to respect her views." Mrs. Dodds, in the interview containing the descriptions of their battles that has been quoted, said "He'd be the first one to say 'why didn't you stop me going it' if he'd done something silly and was ill again. He'd say 'why didn't you stop me?'." While these two families were aware of this reserve role the wife could play if it was necessary, for most families it was implicit rather than explicit. However, it offers some meaning to the otherwise functionless role of Watcher - the wives would watch and step in with authority if they thought things were going wrong. The question of the authority necessary to play the Final Arbiter role was a difficult one for many wives. Whether or not they welcomed the authority must be seen as being influenced by previously established personality and relationship patterns. In taking the authority upon themselves, however, what seemed to be important was whether they could maintain its credibility with their husbands. Their position was generally strengthened more by contacts with the G.P., when they were present for the ^{cons}ultation, than by out-patient appointments when their husbands could see the doctors on their own. These appointments gave the patient alone the up-to-date medical view and instructions, to which his wife was then a party only to the extent that he chose to share the information. In ways

such as this the balance of power in the bargaining situation over authoritative Arbiter decisions would be modified.

One aspect of activity-management had both covert and overt aspects. This was:-

e) Dietician. Almost all husbands took diet sheets home with them from hospital, and for the few for whom this was not formalised into a specified diet, they knew that they must control their weight. The burden of implementing this fell largely on the wives who had to make the day-to-day decisions about shopping and menus. The extent of the change that was required naturally reflected their previous eating habits; for some there was very little change, and the husband could continue to eat the food habitually served to the whole family, just having smaller portions and less carbohydrate; for other families the change was more radical and a decision had to be made as to whether all members of the household would eat diet-menus or separate cooking would be done for the husband. Several wives welcomed the idea of going into the diet themselves as they thought that they were overweight, but even when they did this, they were noticeably less successful in losing weight than their husbands were. The overt forms of this aspect of management were when the spouses discussed and planned menus together or the husband agreed to go along with his wife's interpretation of the diet - she then implemented it as a part of her housekeeping activities. The covert forms were a way of manipulating the availability of food so that her husband had no temptation to eat things that were forbidden. This could be controlled by ensuring that there were no sweets, biscuits or cakes in the house.

2. Mood-management.

The forms of this that were acted out were:-

a) Relieving boredom. Many husbands expressed acute boredom, especially during the early days of their convalescence when they were confined to the house. Wives responded to this by "finding him things to occupy him." They acquired jig-saws, got him to make gifts for the grandchildren, stimulated his interest in his stamp-collection or in playing chess or rearranged the sittingroom so that he could practise his golf strokes. While these time-

filling activities reduced the immediate tension that arose out of his sense of frustration, they were also intended to serve the long-term purpose of 'getting through the time' until his health was better and he could begin to resume some of his normal activities. In many ways, this was very similar to the wives' intentions during the hospital period to "keep him happy" and "stop him fretting." If he could be helped to tolerate the sensation that time was dragging, the healing process would be enabled to proceed.

b) Reducing tension. Some wives saw it as their duty to stop their husbands getting tense or excited. When Mr. and Mrs. Mears were planning a train journey, she agreed to arrive at the station at a time that she thought was unnecessarily early "to prevent him getting tense." Mrs. Hewitt stopped her husband watching sport on television as she thought that he got over-excited and that this was bad for him "He shouldn't, he should keep calm."

c) Reassuring. There were two main ways that the wives tried to achieve this; by denying that he was likely to have a recurrence of the illness and by reminding him how much progress he had already made. This role was used when they thought their husbands were becoming too anxious or were depressed; either to push them towards the 'middle path' or to maintain progress along the path when they thought that he was in danger of becoming stuck. Mrs. Keoghan said to her husband "I underst~~ood~~ that you're depressed, yes. Of course you know you're going to get better. It would be different if you were never going to get better - but when you know you are going to get better, you get impatient waiting for that time." Mrs. Archer, trying so hard to reassure her husband that he was not in danger of a further attack, got angry when he did not believe her and tried ever increasing amounts of reassurance, eventually, as did many wives, using her own experience of recovery from illness to strengthen her argument. Some husbands seemed to allow themselves to be reassured, others concluded that their wives did not understand them, at which point communication over these stressful matters virtually ceased.

Although the wives were not the chief subjects of the study and therefore the data on their reasons for playing this role so frequently are

incomplete, it is still clear that not all the wives who offered massive reassurance to their husbands subjectively felt the degree of confidence that they were portraying. Some, such as Mrs. Dodds, thought their confidence was well-founded so long as he "didn't take risks"; others, such as Mrs. Keoghan, presented a form of confidence, which they admitted in his absence they did not feel. It seems very likely that presurting this atmosphere of confidence was for some wives, as much for their own sake as for his, and that they were using it as a way to defuse the tension that would be experienced if their anxieties were discussed openly.

While both these roles that have been presented at this point contain a large element of the wives' attempts to set limits, it should also be noted that the other facet of many of these roles contained the wives' attempts to stimulate some desired behaviour. Not only did they want him "happy" for the sake of a comfortable atmosphere, but it also made him "easier to manage." Mrs. Berry was the most extreme example of using the situation to achieve something she had wanted for a long time - she thought her husband had been spending too much time at the pub, so her reasons for enforcing the restrictions on his excursions were aimed at achieving this end as well as upholding medical recommendations.

The next two roles were more passive than the management ones.

3. Watchers

The phrases used by the wives to describe this role were "I watch him" or "I'm keeping a check". In his daily activities, they gave their husbands the impression that they could make their own decisions and determine the speed with which they could increase their exercise. But in the background the wives watched what he did to ensure that it continued to be 'middle path' activity. At any sign that he was straying in either direction from this path, the wives would change to a more active role to bring him back to conformity, usually to the Ultimate Arbiter one. While the Watchers seemed at first sight to be relating to their husbands on an adult-adult basis, this was conditional on their "keeping the rules", and their deviation would rapidly return them to the adolescent status.

4. Collaborator.

The wives making this their major role, all indicated that the pre-illness pattern of family relationships had been comparatively free from stress, that they had shared activities before and were comfortable in communicating about things that were of consequence to them. It is possible to infer from this that the other wives who predicted that they would operate in this way but who, when the time came played some other role as their primary one, may have expected that the crisis would make up for the fact that they did not have these pre-illness patterns. When collaboration worked well, it provided the opportunity for a high degree of consensus between the husbands' and the wives' concepts of the 'middle path', in which both could bargain and agree to make concessions. It also proved to be a highly flexible pattern in which they both felt that they were in a process of finding out together and could gain confidence from each other as they identified stages in the husbands' progress.

There were very few wives for whom this was their primary role in relation to their husbands. Mrs. Easton maintained it fairly consistently, moving to another one only when she felt it was necessary - for instance the occasion that has been quoted when her husband tried to "sneak upstairs." Mrs. Neale used it successfully in combination with an open recognition of her role as Dietician. Mrs. Langton tried hard to "let him decide" although her anxiety sometimes got in the way of this.

It is unfortunate that the method of interviewing both spouses together did not make it possible to assess whether the wives who were essentially Collaborators were as confident and free from anxiety as they presented themselves both to their husbands and in the research interviews. Some inconsistencies in their behaviour would imply that they were not and that they were presenting a non-anxious facade - a form of interaction which followed on from the 'mutual pretense' method of dealing with anxiety that was characteristic of the hospital period.

5. Normaliser.

In its full form, this role was extremely rare. Mrs. Gould played it from the beginning when she didn't really believe that her husband had been seriously ill. She began normalising the situation soon after his return home, when she expected him to be able to go to a family wedding. Not long after this, she was behaving as though the illness was a closed book and all was back to normal. Mrs. Mears adopted it after a period of time. When the final research interview was arranged by telephone, she registered surprise "because I'd forgotten he had been ill."

Other wives came to use it after several months as the way in which they presented themselves and the state of the family. Their first response when asked how things were, would be "we're all back to normal", but later when talking in a less stereotyped way, they would indicate that this was a veneer to screen the fact that they were still playing management of watching roles. In this way, it differed from the apparently similar response noted by Davis (1963 p.162). While doing this some degree of the conflict between them and their husbands was masked but this deception did nothing to help resolve their husbands' confusion about their self-definition of their health status. The wives in this way had, perhaps unconsciously, adopted the medical pronouncement "back to normal", which it has already been seen implied a contradiction to the husbands. To receive the same confusion of messages from their wives made the situation yet more difficult.

V. Summary.

In setting out the range of roles which made up the repertoire available to the wives, it must be stated again that most wives played most of the roles at different times according to the response that they thought appropriate to their husbands' behaviour. Even those who can be identified as making any one role their prime one, played others when they thought the circumstances required it. An interesting point arises from this. When the roles they played were harmonious, like the different notes of a tune played in one key, there was a consistency about the message that they conveyed to their husbands. When, however, the roles they selected from the repertoire were discordant,

the tune jarred and their husbands' discomfort became greater. This is not to imply that any roles were intrinsically better than others, but that the combinations which conveyed consistency gave the husbands more help than did the contradictory combinations in resolving the uncertainties of their status with which they were faced.

In saying this, it must be remembered that the wives themselves were often under a great deal of stress because of the awareness that their husbands' lives could easily again be at risk. Because their relationship was both qualitatively and quantitatively so different from the relationship that other units of the role-set had with the patients', their involvement in the process of convalescence was correspondingly greater. This added greatly to the intensity of their concern that their husbands should 'get it right'.

Recapitulating on the medical and non-medical units of the role-set which were discussed in the previous chapter, two levels of use that the patients made of their models was suggested. The medical model was a direct influence, but contradictory and confusing when being implemented. The 'wise' and 'others' models were used to reinforce the sense that the patients had made of the medical model as it had been channelled through their interpretations. The wives' model can now be seen as coming at a level between these two; it was closely allied to the medical model and sought to draw its authority from it, but at the same time the wives had their own views and past history which gave them a more immediate influence than the 'wise' and the 'others' could command. The wives also, in clarifying their own ideas were being influenced by the 'wise' and the 'others'.

In these ways the units of the role-set were interacting and the four units together may be conceived of as influencing the patients' experience of convalescence. The next chapter turns to an examination of that experience in the light of these influences.

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7. THE PATIENTS' MODEL OF CONVALESCENCE.

Surrounded by this set of people with whom they were interacting, each patient had to find his own way of mediating between the various influences discussed in the two previous chapters, and his own perceptions in order to discover the path that he thought his own convalescence should take. This interplay was continuous and underlies all of the following discussion, even before it receives direct attention in the final section. An additional underlying theme which the following discussion subsumes was that the patients and their families were in an immediate post-crisis situation in which the risk to life was still very recent. The sense of uncertainty which continued with them for much of this period, can only be adequately understood in the context of the perceived precariousness of his life. In the midst of this uncertainty about the 'right path', they were aware that to get it 'wrong' could lead to a recurrence of the illness and perhaps to death.

The chapter is mostly devoted in a long first section to an examination of the ways that the patients perceived convalescence and the action that they took to resolve its uncertainties. This discussion moves from the most theoretical, in which the dilemmas resulting from ambiguous health status are indicated, through a middle-range level of abstraction in which the factors affecting the lateral scope are analyzed, to the most concrete which examines the decision-making process as it is seen in discrete activities. The section concludes with a tentative classification of some of the patterns of the process. The second section considers the difficulties in identifying the end of convalescence. The third section relates the patients' experiences to the models presented by the units of the role-set.

I. The Patients' Experience of Convalescence.

a) Attempts to determine health status.

The difficulty of understanding their state of health preoccupied all of the men at, at least, some stage of their convalescence, and often throughout the whole of it. Because it was surrounded by so much uncertainty, the day-to-day decisions and long-term expectations for the future were often problematic. The usefulness of Patrick, Bush and Chen's (1973) view that

"health status is a composite of an individual's level of function at a point of time and his expected transition to other levels, more or less favourable, at future times", has already been acknowledged. This thesis not only takes that position but adds to it the relevance of the past, as colouring the perceptions of present and future.

All patients talked of the period of acute illness during the interviews after their discharge home. While this is not in itself surprising, and they may have thought it an appropriate area of conversation with the researcher, the content of many of the comments is very revealing. In various ways, they were attempting to re-evaluate the episode, as though a clearer understanding of it was still important to them. This sometimes took the form of revising their view of their pre-illness health in a way that made the heart attack less inexplicable. More often, however, the major concern was with how serious or mild the attack had been. While this interest might sound like a wish for a clinical classification, the relevance of these comments to the present is the desire to sort out the extent to which they must still consider themselves sick - operating on the notion that if the attack had been serious, they must continue to consider themselves sick for longer and the future was more uncertain. But whatever the perceptual devices that they used to classify their own condition, they had little or no opportunity of checking this with a clinical assessment. Whether or not the self-definition agreed with the medical classification and whichever the category into which they placed themselves, there was no correlation between these and such measurable data as length of time off work.

The other recurring theme in their retrospective view of their illness, which continued for several weeks after their discharge, concerned their continuing dependence on the hospital. There were two aspects to this; firstly, that of security - those who had felt "safer in hospital" or who had been "reassured when I had pain" because there were always staff at hand; secondly, those who referred back to the hospital as having set out a model for the control of their activity, which they were still trying to implement - "the hospital said 'Don't do too much'" was said by Mr. Gould who remained

very anxious about resuming any activity.

Although these thoughts were attempts to clarify their ideas, their main concern centred on their health status in the present. During their time as in-patients, they had learnt to distrust their own subjective assessment of this and instead to rely heavily on the medical definition of it. Once at home, however, they had less frequent access to any professional opinion and were much more vulnerable to their own doubts. These doubts were expressed by many patients. Mr. Jessop, for instance, put it - "You don't really know whether you are cured or whether you ain't....difficult to know how well you are." Those who tried to hold some absolute concept of health, found that it had to become relative, either to their improvement from their previous stage or to their age. Mr. Easton put it "You think you feel well when you come home, but you're getting better all the time....A week later, when you're doing a bit more, you think 'Well, I wasn't as well as I thought I was then....At the time you don't notice....but a week later you realise Well, I'm doing a bit more now." Mr. Jessop, after a prolonged period of doubt, came to the conclusion "I'm as well as I'll ever be."

Before discussing the ways by which they tried to measure their health progress, it is worth noting the additional complication in assessing this which results from the heart being an internal organ, the functioning of which is invisible and merely subjectively known. Mr. Archer put it "It's not like a broken leg or a cut on your arm, when you would know it had healed. You can't see this and don't know what was happening." Others drew contrasts with operations when it could be seen that healing had taken place.

In the absence of these visible criteria, much of their assessment of progress was related to their amount of activity. This approach was usually phrased either as "I won't know how well I am until I try to do more" "I try doing things to feel how fit I really am" or "I don't want to be ill", given as a reason for increasing activity. Achieving certain tasks was seen as a measure of improvement in their health. The difficulty about this method of assessment, though, was that their health and the trial tasks were mutually dependent, in a chicken and egg relationship, as, even attempting the task

was in itself dependent on their recognising some improvement in their health. The virtual impasse that might have occurred because of the mutual dependence of these two spheres of progress, can be seen to be resolved by the introduction of a third area in which they could place more faith because its subjective reality was the only reality that mattered. This was their own view of themselves on a Confidence - Anxiety continuum. Their position in relation to this was often patchy and inconsistent, and frequently vulnerable to passing events, but for them, at least, it was real. The effects of this could work either way and by drawing them in a circular relationship, the interplay between them may be seen diagrammatically as:-

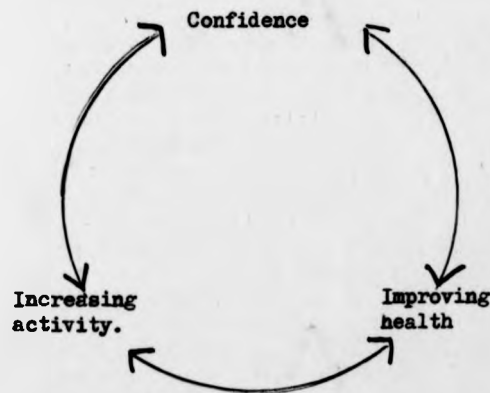


Diagram 19. Interplay of Confidence - Activity - Health.

This circular arrangement allows for otherwise opposite statements to be understood within the same schema. Those patients who said "My confidence is growing because I can do more" and those who said "I do more, because I am more confident" were all working out the relationship between their health assessment and their level of activity, although going about this in different ways.

While the anxiety that was specifically focused onto the possibility of a recurrence of the heart attack will be discussed in the second section of this chapter, it should be noted here that more generalised forms of anxiety and depression occurred in a third of the patients. This depression, which was sometimes medically recognised and on other occasions identified by the researcher, inevitably interrupted the development of confidence. Only one person saw it as a new feature to his health status - "I've had a set back - my nervous system has gone back a bit", while others saw it as a change in their feeling state resulting from the illness and the slow progress of their improvement - "I got depressed. I wonder to myself if I'm ever going to be right - really right again."

One of the main factors which upset the development of this confidence was the recurrence of episode of pain. It has already been suggested that the patients felt that they had inadequate information about both the causes of their continuing pain and of ways of deciding what action to take. More than half of the men in the Full Series spoke of the anxiety that this pain caused them. Mr. Keeghan was very specific about this - "Everything went tight and I had the pain - the same pain as before, but not so severe. I took my tablets and sat in the garden for a while. The pain eased but then came back - it went on till 9 o'clock. My wife, she wanted to call the doctor....it was still there in the morning....I didn't get the doctor - what could she do - I'd got the tablets. When I saw the doctor the next week she said 'You handled it well - you didn't panic - it was severe angina'.. That angina knocked the stuffing out of me for three days - I said to the doctor 'I think I've had a mild heart attack'. It's the first time I've been really frightened - not frightened of dying, but of going through what

I'd gone through before." Mr. Gould had pain quite frequently - "I had a rather sharp pain last week on the night shift and again this morning....I didn't know whether to go to the doctor....I've told him about it before - he said it might be in the mind, but was nothing to do with the heart....It's difficult to tell. When you've left hospital, you sort of imagine something's wrong nearly everytime. Sometimes I forget about it and work like normal.... by the end of the shift I'm out of breath and begin to think I've done too much. It's always at the back of my mind....the doctor would probably say 'It's nothing'....You keep worrying when you get any ache or pain - it's when you're feeling low in yourself - which could be for a hundred and one reasons, like any normal person - but you automatically think it is that. You can't keep running to the doctor every five minutes with every ache and pain. You've got to live a bit dangerously and chance if it's this or not."

This dilemma over whether or not to see the doctor did not, as is sometimes suggested, reflect any reluctance to seek his opinion, but rather a basic difficulty in distinguishing trivial from serious symptoms and 'normal' pain from the onset of another heart attack. If their judgement erred on the side of caution, they feared wasting the doctor's time and being a 'bad patient' - if their judgement was too casual, they feared a repetition of the frightening illness. Mr. and Mrs. Langton had great anxiety about this until their G.P. gave them some definite criteria by which they could evaluate the pain and decide what action was appropriate. Comparable advice would clearly have been helpful to other families.

A related aspect of uncertainty and the need for clearer advice concerned the taking of medication. In almost all cases, the patients who spoke of continuing pain also spoke of reluctance to take the tablets which had been supplied for the purpose of easing these pains. While for some people, it seems that the instructions about when to take them had not been clear, for others the reluctance reflected their uncertainty about their health status - carrying the tablets with them and taking them voluntarily became equated with recognising a continuation of the illness. The fear of "becoming dependent on the tablets" reinforced their doubts about how well they were and how well they could hope to be in the future. This resistance,

however, only seemed to apply to those tablets over which they had to make their own decisions. When they spoke of medication for which a daily dosage had been prescribed, they indicated that they took it regularly, which may be seen to imply that this form of prescribing had fewer problematic implications than did the self-prescribed with its connotations of self-definition.

Although part of the ^{process} ~~process~~ of convalescence was resolution of these uncertainties which surrounded their understanding of their health status, the progression that this implies was marked by fluctuations and inconsistencies - the patchiness which characterised so many aspects of their experience.

The possibility of tracing through the present until it had become past, and the future until it had become present was a feature of the research design that had already been noted in Chapter 4. The patients' perception of their health status at the time that the research ended reflected the resolution of their dilemmas that they had worked out as the process evolved. Although they spoke as though their view of their health status at a point about six months from the illness implied their expectation for the future, clearly this study was not designed to investigate changes which took place at a later date. At the six-month time period, there were six main groupings into which the health perceptions fell:-

1. "I'm better than before." These were men for whom the new health behaviour they had adopted, usually in the form of weight loss, had increased their sense of well-being.
2. "I'm fine - as well as I'll ever be." These men had adopted a new and relative form of the Well Status with which they could live without intolerable ambiguity.
3. "I am more realistic because I've realised my age." By modifying the norm by which they evaluated their health, they could consider it satisfactory.
4. "I'm uncertain - there are no usual guidelines." This formed the peak of ambiguity between the Well and the Ill Statuses.
5. "I'm always aware of my heart." These men found that their continuing

concern about their symptoms meant that they rarely thought of themselves as fully well.

6. "I'm not really well, because my activity is restricted." These men were still defining themselves as sick, to a greater or lesser extent, even when this self-definition caused them discomfort.

To find this range of view of their health position among the eleven men who were seen for the full six-month period, confirms how unrealistic it would have been to attempt to build a theory about patterns of crisis-resolution when there was such diversity within a small sample. It is, however, reasonable to state that there was, for many of the individuals, a theme within their perceptions which linked their view of the dilemmas of convalescence with their position at the six-month point of time. These links would, though, need a very much fuller exploration before they could be proposed as predictive factors.

The patients' dependence on the doctor as the major definer of his health status had been referred to on many occasions. It needs little further elaboration, except to note that it continued throughout the period that each patient was off work, at the end of which the doctor had to re-define him ^{as} medically and administratively as fit for work. The implications of dual-doctoring have already been discussed in Chapter 5.

b) Range of possible activities.

When they were first discharged from hospital, three things happened simultaneously; the range of activities that were open to them widened suddenly, they had to rely on their own decision making processes to a greater extent as to which activities to undertake, and they became increasingly available to the influences of their role-set.

In the initial period, the disruption to 'normal' family life was at its highest - the structural changes have already been referred to when discussing the wives' position. In addition to this, normal family routines such as time of getting up in the morning, ways of spending time, and the allocation of tasks were ^{it}acutely abnormal. With the exception of Mr. Berry, who "didn't want to 'be ill'", and Mr. Neale who "thought I was well again",

the patients took into this first phase their individual interpretation of the sick role and chose their activities accordingly. With some semblance of normality around them, though, i.e. that they were back in their own home, the abnormality of their daily activities seemed to stand out in more stark relief than it had while they had been in hospital where the whole situation had been acutely abnormal. Mr. Hewitt was one of the men who talked with great feeling of the boredom that he experienced once he got home; the restrictions on his activity seemed more ~~irksome~~ to him there where he had to make his own decisions, while, in the hospital, "I had been able to settle down more, 'cos I knew what I had to do."

This sense of boredom was referred to by most of the patients, and had no correlation with how limited their activities were to an outside observer. Those confined to the house and those going out for walks or in the car were equally likely to speak of it. This lack of relation to any objective scales of activity focuses attention once again on the importance of the individual's perception of his situation as being the only one that has meaning to him. There were, however, two recurring items which did correlate with the expressions of acute boredom. The first was that each of the men had a high personal investment in activity, usually as a way of maintaining their self-concept. Secondly, that at the beginning of their convalescence very definite boundaries were set to their permitted activities by either their G.P. or their wife. An apparent contradiction exists here, in that a theme that is central to this thesis concerns the difficulty of lack of certainty and of ambiguity which marked much of the convalescent process. It is now being suggested that those that had specific instructions also found this difficult. However, the contradiction is not as marked as might appear. The problem of boredom, while it was difficult for the men to tolerate, could also be functional by giving some clear limits, by easing the burden of self-decision, and by underlining the steps and stages of progress. Thus Mr. Dodds, after he had been at home for a week, was very frustrated because his G.P. set close and specific limits to his activity, but he also knew the expected timetable by which these limits would be extended, and this kept him aware of development and progress.

While the response to a limited range of activities was in part a personality one, in that it reflected personal investment, and in part a pattern of responding to authority, it also was affected by the goals that were held for the future, the predicted and result of the period of illness. In this way past, present and future were again inextricable. While predictions about the future were subject to great fluctuations and inconsistencies, which will be discussed later, the fact of having some goal to aim at was important in trying to make sense of the present. Each person's view of the future, and the varying investments that this involved affected the range of activities that were considered to be possible.

It has so far been implied that the range of activities each person thought was possible for him came from certain segments of his pre-illness norms. While this is true, it is only a part of the truth, as almost every man consciously included certain aspects of new behaviour within his activities. This new behaviour concerned either medically prescribed or self-decided forms of health-promoting or illness-avoiding activity. The prevention and promotion aspects of this new health behaviour are almost impossible to separate except at levels of generality. Health promoting behaviour tended to be rather diffuse and couched in terms of an intention to improve their general physical condition; efforts for which they often found there was a considerable subjective reward. Those for whom an increase in their physical exercise combined with a sense of well-being from losing weight felt that their over-all health had been improved by their own efforts and that they were "better than before" the illness. The more specific illness-avoidance behaviour overlapped with this in matters such as diet and sometimes smoking, but when expressed as avoidance behaviour, it was an unwelcomed restriction imposed from the outside which was seen as a restriction that might be tolerated because of the fear of a recurrence, but from which there was no subjective satisfaction.

Smoking behaviour is a topic of such contemporary concern that some factual details may be worth including for the purpose of comparison with other studies. Of the Full Series sample of eleven men, seven were established

smokers before they became ill, smoking either moderately or heavily. One of these smoked a pipe, which the doctor permitted him to continue. At the end of the six-month period, three had not resumed smoking, although one of these was still finding it so difficult that he was considering restarting. Of the three who restarted, two did so quite soon after their discharge from hospital, reckoning that they could limit the number of cigarettes they smoked to a fraction of their previous habits but gradually increased this to as much, if not more, than they smoked before. The third resumed smoking towards the end of the research period in an attempt to control the weight that he had gained. The convergence of three areas of restriction - of activity/interest, of diet and of smoking - added greatly to their difficulties in maintaining any one of them.

This new health behaviour was more vulnerable to being abandoned as time passed than were other changes in their pre-illness activities. This, it is suggested was because unless they found positive gain from it, in ways such as a heightened sense of well-being, the negative aspects were implemented mainly out of a fear of precipitating a recurrence. As the fear of this became somewhat less acute over time, the urgency of preventive behaviour also lessened. As their confidence that they still had a reasonable life-expectancy grew, they were concerned that it should be worth living. As Mr. Hewitt said, "If you've got to cut out everything, it's a waste of time... you might as well pack up all together."

This necessitates some discussion about the ways in which the fear of a recurrence of the illness was handled, and its effects on the range of activity that was undertaken. Eight of the eleven Full Series patients talked of their anxiety about a further episode of illness. Any common wisdom knowledge that they had had about the possibility of this had been confirmed during their time in hospital when they met patients having second or subsequent heart attacks. Their fear about it centred either on the chance of a second attack being fatal or on a repetition of the pain. Those who did not speak directly about the fear, implied it when talking about their reasons for trying to implement their new health behaviour; by their own

efforts, they could control the future risk. Mr. Fraser, talking in this context said "If anything goes wrong, it won't be their (the doctor's) fault, it'll be mine." Similarly, Mr. Mears, at the end of six months, said "I still think about it and being in hospital....I still think, if I push a little bit, I might bring something on."

This fear of a repetition was a crucial factor in the development of confidence that was discussed in the previous section. The dilemma they were faced with was a very real one. Mr. Archer talked around it, while his wife tried to argue with him to reassure him - "There's always that feeling in your mind....it'd happened once, it ~~could have happened~~ ~~once~~, it could happen again....there's so much of it, with no warning....I feel well, but how do I know, it happened so suddenly before, and I felt well then." For this sort of awareness, there could be no satisfying answer, and the patients were conscious of how hollow reassurances were. The passage of time, and the confidence which grew with mastering increasing activity were subjectively the most real forms of reassurance, although some patients remained acutely anxious at the end of the six-month period.

The verbal efforts to reassure the patients that were made by doctors and wives were almost always couched in the context of contradictory statements and behaviour. The doctors at the same time both reassured and urged moderation or new health behaviour. Mr. Mears, following his remark quoted above ~~said~~ "I told the doctor what I was thinking and he said 'You want to forget all about it now. Let's say this is the last time we're going to hear about all this. It's finished'. The doctor at the hospital, he said 'You can go out of here and do anything you was doing before you came in. But don't go running for buses and don't go pushing cars around'." The juxtaposition of these two pieces of advice, at the same time reassuring about the future and also setting some limits meant that many patients when presented with these dual statements did not know what to believe. The wives also frequently conveyed similar contradictions in their selection of the roles that they played - a point that has been made in chapter 6.

The prevalence and intensity of this anxiety about a recurrence of the illness would not be a major feature of every kind of illness. Even in those where it might be expected, such as malignant conditions, its implications might be different as there would be less expectation that the individual's behaviour could influence the likelihood of its happening. Possible parallels might be found in complications of pregnancy or arthritis in which excessive activity could lead to a medical deterioration, but the situations are not entirely similar, as in the first a time-span can be fixed and in the second, life is not at risk. The extent to which this factor in convalescence is unique to acute cardiac conditions would need to be investigated by parallel studies focusing on other diagnostic groups.

Although it has been said that only some of the patients remained overtly inhibited by their anxiety by the end of the research, all eleven of the Full Series intended to perpetuate some of the changes that they had introduced into their lives while they had been convalescing. These were usually phrased in very general terms such as "I'll take life steadier", "I'll make less exertion" or "I'll not rush around" - all things which were hard to be specific about, but which reflected an attitude to themselves and their life. Eight men were, however, more specific when they were talking about themselves in relation to their work. Although only two changed the jobs that they had held before becoming ill, and they remained within the same firm, six other men predicted, and often at least initially implemented, changes in the way that they did their usual job. They either adjusted their hours, worked less overtime than usual, or reorganised it to avoid physical or mental strain.

Seven of the eleven men spoke of feeling older as a result of the illness - usually putting it in terms of "recognising my age." By this they meant that their self-concept had had to be adjusted so that they identified with the age group into which their chronological age placed them. In doing this, it may be assumed, they were finding a way of explaining to themselves the changes in their life-style which was less fraught with contradictions and problems than if the reason for such changes were to be laid at the door of their uncertain health status.

The persistence of any of these changes beyond the six-month period cannot be assessed in the present study. There is insufficient material on which to base predictions, although some indication of potentially significant determinants can be suggested. All except the acutely anxious patients said that "things were back to normal" and it was only by encouraging further discussion that the changes that have been outlined were described. There were, however, qualitative differences between the ways in which this 'new normal' was perceived. Also, each person had differing perceptions of and investments in different aspects of the changes that he had instituted. While the grounds for some of these differences will be discussed in the next section these can only be suggested tentatively as indicators of future behaviour.

c) Decision making about activities.

Having considered some of the wider and more general issues which determined the range of activities that were undertaken during the convalescent period, it is now appropriate to discuss the ways in which these decisions were made. The aura of importance which surrounded these issues, because of the risk to life, coupled with a high degree of uncertainty made this an area which was especially open to influences from the role-set.

The Threat - Loss - Value schema continues to be a useful model for analysis of the decision making process, ⁱⁿ that it allows for each activity or potential activity to be considered both independently and also within a general pattern. The generalised pattern of increasing confidence and lessening ambiguity, in those instances where this happened, meant that a wider range of activity no longer needed specific thought and conscious decision making; it could be resumed as part of 'normal' behaviour. In talking about his steady increase in activity, Mr. Easton said ^{it's} "It's been what I felt I could do....it shows the improvement, that at first when I went up to the shops and back, I felt I'd done enough - since then, I can cope with it quite easily" - an activity which at first needed thought and was an event, had resumed or taken its place within his natural repertoire of behaviour.

While the Threat scale tended to become less predominant as time passed,

the Value scale tended to become of increasing importance. It had been noted earlier, that in the early stages of the illness, the patients' pre-existing value scales were subject to radical revision, not only in re-evaluating their past lives, but also in rendering any change in their life-style tolerable if it would keep them alive. The passage of time, and the reduction of the general level of Threat, however, meant that the old values were more likely to reassert themselves. Some newly instituted health behaviour was abandoned, such as Mr. Keoghan's intention to take more exercise, and other previous behaviour was reinstated, such as Mr. Berry's heavy drinking for social reasons. The Loss/Gain scale was generally less subject to fluctuation, on both a general and a specific level.

Within these general trends, discrete decisions had to be made about each activity which contained an element of doubt. Its position in relation to Threat - Value - Loss had to be evaluated in the context of a particular point of time, of its significance to his understanding of his health position and in relativity to other activities. To illustrate ^{an example can be drawn} this from Mr. Keoghan's discussion of gardening, which was his major hobby. While he was in hospital he could not imagine resuming it for a long time, although this upset him. Soon after he returned home, he was more frustrated about it, thinking he could do some light tasks, but had better not. A month later, he was doing some light garden jobs. At the final interview, which followed a period of severe depression, he had lost interest in it and "couldn't be bothered." This particular activity had for him a 'life history' of its own which in many ways was out-of-step with his other selections of activity, for instance while he was still not gardening he had begun to do housework, an activity which held low Value for him except in so far as it occupied time. The gist of this argument is that each individual made idiosyncratic decisions and selected between activities in a way which seems totally inconsistent unless the general and specific Threat - Loss - Value content is understood.

While no two patients made identical decisions about their activity, they each one saw their own choices as "being sensible." This was their version of the 'middle path' which was being advocated by their wives.

In doing this, they used two criteria in addition to those already discussed. The first of these was a subjective one - the point at which they felt tired. The second presupposed some ability to assess the amount of exertion required for a task. There is a very interesting notion imbedded within this supposition, which would merit further exploration in a future study. The patients thought that they could distinguish and compare the physical effort involved in different kinds of activity. Thus Mr. Neale for instance, cut the lawn with a hand mower, but did no digging or lifting - "I thought, that won't hurt me. I've done no heavy work what I've been used to doing." The notion underlay a wide range of decisions, and affected them in either of two ways. If he said he would do activity A, but not activity B, he was justifying both decisions by contrasting the exertion required by each of the tasks. If, on the other hand, he said that doing activity C would mean that he could do activity D, he was considering that they fell within the same category.

There is a risk of implying in this discussion that all decisions were made consciously and within some logically-thought-out framework. This, however, would be a distortion and must be corrected by a statement that most parts of the framework that is being set out are theoretical constructs drawn out from an analysis of the meaning of the patients' statements. Yet, an additional area requiring further study arises from this. Some patients were much more conscious of their continuous decision making than were others. Some said "I think about it before I decide to do X"; others said "I do things without thinking - just naturally - and then think afterwards about whether I should have." From the small numbers in this sample, there are no clear correlations between either of these two orientations and factors such as:- age, class, occupation, level of general anxiety, persistence of pain or intelligence (as assessed impressionistically). As variables they would seem to be important as approaches to the selection of activity, although this cannot at present be fully understood. Any future study which pursued this area further might also have the methodological difficulty which existed in the present one, in which the very fact of asking people to verbalise on their decision-making activity may in itself change the process for some of

them by making it more conscious.

In their choice of activities, the patients were not only reflecting their perception of their transitional position between the Ill and the Well statuses, they were also defining it. Two aspects of this may be noted; firstly their acceptance of some of the criteria of the sick-role, and secondly their rejection of it.

Their acceptance of a continuing sick-role as far as work was concerned was imposed on them in a formal sense by administrative constraints. This, in itself, did not necessarily mean, though, that they would disengage themselves from interest in and involvement with work. While it was expected that this might be found among those men with repetitive jobs who had little personal investment in their work, it was more surprising to find a similar response among the white-collar workers who might have been assumed to have a higher level of continuing involvement. Mr. Easton, for instance, who as area manager for a building contractors had several major sites for which he was responsible, said "Some people feel they're indispensable....I've sort of kept in touch....they ring up sometimes^{mes} to ask something....If you keep trying to put your spoke in - A, it's useless - and B, 'he's supposed to be sick'.... I never worry that I'm being missed or they can't do without me." Mr. Dodds, who had been established for a long time as a senior executive, compared his absence from work with being on holiday - "when I can drop it....There's nothing you can do." The exception to this usual pattern was Mr. Langton who was a joint director of a small private firm. He began to resume some involvement in work soon after his discharge from hospital - "for the best part of a week now, I've taken an interest....I want to try and keep my finger on things a little bit more. It's so important for us, of course, from the financial point of view." With work of that kind, he could discuss issues from his home, although it was fourteen weeks before he was 'signed off' to return to work fully. Most of these men were, therefore, implementing in the work context the spirit as well as the letter of the first of Parson's (1951) attributes of the sick-role - "The exemption from normal social role responsibilities....the legitimation of being sick enough to avoid

obligations can not only be a right of the sick person, but an obligation upon him." (p.436-7)

This same aspect of Parson's formulation was, however, seen by the patients to have negative connotations in terms of some of their other "social role responsibilities", and they rejected these whenever possible. While this observation supports the need which has been demonstrated by many other studies already quoted to refine Parson's concept, it may also in the present context, highlight the patients' confusions about their health status and the difficulty of combining ill-behaviours with healthy - behaviours. The topic of discussion which most frequently illustrated this desire to reject 'ill-behaviours' was their sense of dependency and uselessness when their wives were doing tasks which they thought appropriate to themselves; the one referred to most frequently was their wives carrying the shopping bags when they were out together. If the role-responsibility exemption spread to too many spheres of their lives, they "felt useless".

Underlying¹³³ all this uncertainty and doubt about decisions over activity was the sense of shock from which they were often still suffering. The Langton family, for whom the husband's illness followed soon after the acute illness of their eldest son, found that it was six months before the sense of shock eased. At a half-way point in the research series, he said that he had given up some initial ideas about changing his job because "now I've become a little more rational." By the end of the series, they were both speaking about "beginning to achieve a sense of proportion." Although the state of shock did not last as long as this for most other patients, they were all aware of it to some extent. However fully, therefore, theoretical explanations of their behaviour might be developed, the irrational, emotional features of some parts of their behaviour should never be overlooked.

d) Patterns of progression.

There were three very broadly grouped patterns of progress through the convalescent period:-

1. Smooth progress.

This term is not used to mean either that the convalescence was

unproblematic, nor that the same end-point was reached by each person. It is used to imply that progress along the many inter-related dimensions was maintained with at least moderate consistency throughout the period. It is suggested that an optimum amount of tension both between the different models of convalescence and within an individual's perception may have been functional in maintaining this dynamic character.

2. Interrupted progress.

This is distinguished from the first pattern by any one of a number of possible events which diverted the patient from the path originally chosen. It may be subdivided into:-

a) Honeymoon. On their discharge from hospital, these patients thought that they were 'out of the wood' and their problems were behind them. However, a recurrence of pain, an awareness of their slow physical improvement or major discrepancies between their model and another influential model set them back and often resulted in a period of depression, which in its turn hindered progress.

b) Out-of-step. For these patients, the basis for communication between them and their wives broke down as the relationship seemed unable to contain the stress of sharing their anxieties. Having totally rejected the model that their wives presented, (which was meant to be reassuring) they had to make their own way in an atmosphere they found destructive and unsympathetic.

3. Institutionalisation.

Some patients worked so hard at consciously adapting to the abnormal behaviour which characterised convalescence, that the 'normal' came to seem strange. Others found that this happened spontaneously as they became used to new routines, often leading to expressions of anxiety or self-doubt about returning to work.

Because the boundaries between these groups are fluid, and they are not mutually exclusive no attempt is being made to quantify them. They are proposed as a roughly sketched description of some of the paths that were taken, and it is recognised that much more work needs to be focused onto this in future studies.

II. The End of Convalescence.

Because a central theme of this thesis is the need for a time-orientated view, it is important to consider not only how long the patients expected their convalescence to last, but also the ways in which they identified the ending of it.

It has been said before that although their period of time away from work was medically determined, this was open to certain bargaining procedures between a patient and his doctor. Apart from special features of an individual's work situation, such as Mr. Jessop's need to negotiate with his firm for lighter work, the doctor was largely dependent on how the patient reported his state of health. "The doctor asked me 'How are you?' I said 'I'm fit for work'." But if he thought the patient was being too slow, he might apply a norm not known to the patient - "The doctor said 'It's time you were feeling all right'." By the expectation that the patient should return to work, the doctor made an administrative decision that convalescence was ended.

But, as has been discussed in previous chapters, the doctor as also frequently implied that some features of the illness were not finished - "Back to normal, but watch your activity" was the dual advice given to many. This could be seen to indicate a qualification to the end of the illness itself. The other medical action that was endowed with significance in this context - continuing the interpretation learnt while in hospital - was whether they stopped regular medication and discharged the patient finally from the out-patient clinic. Each of these marked an end to some aspect of the episode, although even that was not completely clear cut - Mr. Hewitt was told "there's no need to go again, unless I have more trouble."

The administrative and 'clinical' ends to convalescence were not necessarily identical, nor did they always coincide with the patients' and wives' perceived end, although they influenced this. The perception was an intangible attitude, which most patients found hard to put into words, although they could indicate whether they felt that the episode was in the past. When reviewing the whole experience in the final interview, those who had by then completed the process said things like - "as though it had never

happened", "it seems a long while ago" or, more tentatively, "I try to make it a closed book." These patients, usually not the most anxious, implied that they had brought together the reassuring parts of the doctor's words and actions, their own subjective feelings of being well, and their growing confidence that another attack was not inevitable. Mr. Easton tried to achieve a workable perspective - "it's diminishing into the distance - to realize that I've had a heart attack - I suppose this is the thing that you've got to watch that you don't let it diminish too quickly, so that you don't...., but then, at my age, you don't do all that many violent things." One person, Mr. Langton, thought the process was still continuing - "it's not completely behind me yet" - even though he had been back at work full-time for two months and was very active. For others, who were still largely preoccupied with their heart, "it seems like yesterday" or "it doesn't seem long ago." When husband and wife shared this perception, it seemed of little consequence to them that their subjective end was timed differently from the doctor's view of the end. When, however, husband and wife disagreed about this, there was more likely to be tension and confusion. Although the illness was still very real to Mr. Mears, his wife had forgotten about it. When I telephoned to arrange the final interview she seemed surprised, and said afterwards that she had been - "I thought, oh yes, he was in hospital, wasn't he....it reminded me because I don't think about it....he doesn't give me any reason to think about it." In other families, the husband considered the episode finished, but the wife was unsure and watched his health closely as though the illness was continuing.

One unusual means of demarcating the end was expressed by one family in the final interview of the series - "Up to a point it's been rounded off, but that's because we've been involved with you - now it's rounded off." This unintentional effect of the research could perhaps have been avoided a more impersonal and detached interviewing style, but remains a potential risk if the relationship is close enough to get near to the real situation.

This extreme ambiguity about the ending of convalescence, and the confusion that resulted from the differing definitions of it offers a

further example of the difficulties that the patients experienced throughout the whole process. The reality of this, emphasises the impossibility of attempting any clear classification about the 'end-^{result} result' of their illness. It also serves to underline the abstract nature of the diagrammatic presentation of convalescence that was suggested in chapter 4. Diagrammatically, the end of convalescence had to be shown as a definitive point in time, though it has now been shown that there were in practice many 'endings' and that in some cases the process might continue indefinitely.

III. Responses to Models Held by Other People.

The continuing exchange between the model of convalescence held by a patient and those held by each member of his role-set has been discussed throughout the thesis, and only a few further points need to be made in this final section.

The patients' dependence on the medical model continued throughout the period, and was still real even after the end of convalescence had been subjectively recognised. Although it was variously interpreted, it remained the major authoritative source; the difficulty of understanding its implications for daily living and self-perception continued to be a source of confusion.

The wives' model, while lacking the authority of the doctors', was the one with which the patients were most familiar, in that they interacted with it continuously. It was therefore the most used, but also the most criticised of all the models. In that the wives' models had lateral and longitudinal dimensions of their own, both these aspects impinged on the husbands, with either, both or neither being accepted and being incorporated into their own model. Where rejection of the wives' models occurred, it was usually partial and more often centred on the lateral aspect - the range of appropriate behaviour. A study covering an even longer period of time might, however, have found that discrepancies over the longitudinal aspect increased with time.

Of the eleven men in the Full Series, ten indicated some measure of disagreement with the lateral span of the model their wives held. Nine of

these thought that their wives were too cautious or underestimated their capacity for activity, either in trivial or in major ways. While some families could discuss these differences, and reach a consensus through a process of argument or bargaining, others used confrontation with considerable anger on both sides. Some husbands agreed unwillingly to conform to their wives' models, even though they seemed wrong to them; other husbands "sneaked round" the restrictions when their wives were not there. The one patient, Mr. Gould, who had a different form of disagreement with his wife, thought that she expected him to be able to do too much, and, on the longitudinal plane, that he was fully recovered soon after he left hospital. The one family where no disagreement existed was in a very comparable position to the others in terms of their general situation, but the wife played a very passive form of Collaborator role, in which she could barely be said to hold her own model of convalescence at all; she took hers from her husband's.

Mr. Gould whose situation had just been described, illustrates the difficulty of separating the lateral from the longitudinal dimensions. Although distinguished for the purpose of discussion, the two are really inseparable. The issues to be resolved were 'How much (laterally) at this point of time (longitudinally).' Some of the disagreement about the range of activities was, therefore, really a disagreement about the pace of progress. If the wives' pace was slower, or occasionally faster, she would try to operate the lateral range that she saw as right for her perception of the stage, but this would be out-of-step with the husbands' view of the range appropriate to his scale of progress.

Little needs to be added to what has already been said about the husbands' need for and use of the models presented by the 'wise' and the 'others'. These served a useful purpose in clarifying and justifying the path that each individual patient took. They were discussed in an atmosphere of considerable interest and often criticism, but without the highly charged emotion and involvement which was reflected when the wives' models were at issue.

The ways in which husbands and wives communicated over the issues surrounding the convalescent period could be observed by the interviewer because the research design meant that they were seen together. While each marital pair had its own established habits and styles of communicating, which largely continued into this period, the highly charged events surrounding the illness had a potential for modifying these. Whatever the extent to which this happened spontaneously, the research design itself by interviewing them together tended to increase their communication. As may be the aim of joint interviews which have a therapeutic purpose, there was often an increase in the extent to which they shared their feelings and experience. On many occasions either husband or wife said "I hadn't known you thought...." But because these were not therapeutic interviews, great care was necessary over this, to ensure that any change that the interviews initiated did not increase stress between them during the following time. While a safeguard to this was the unstructured form of interviewing which left them great freedom to give or withhold information as they saw fit, there was one occasion early during the fieldwork when this was not sufficiently carefully monitored, and both spouses were ill-at-ease with each other at the end of the interview.

The most usual topic over which they had not communicated until they did so in the interviews was their anxiety about the illness itself. Mrs. Archer did not know her husband was worrying about the possibility of a relapse; Mrs. Langton did not think her husband was well enough to go to a wedding, so unknown to him, laid on plans to bring him home from it. Other topics included the ways that husbands had been able to rearrange their work demands to avoid exertion, and the family's responses at the onset of his illness. In these two last instances, it is not possible to account adequately for the absence of prior communication. In the case of communicating about anxiety, however, a continuation can be traced of the patterns that predominated while he was in hospital. The interesting difference, though is that during the hospital period, each thought that they could estimate the anxiety level of the other and accepted the facade as reassurance, and

there was an assumption that they would be able to begin to communicate about these matters once he was at home. Subsequent events showed that it was more difficult to begin communication about anxiety than they had anticipated.

As interviews broke through the initial formality and relationships were established, spouses could begin to indicate some of their areas of anger with each other. Apart from the Barry family, in which there had been marital conflict for some time, and where the intense anger expressed over his convalescent behaviour seemed to be but a new focus to the pre-existing strain, the marriages which were able to recognise their anger towards each other tended to be those with particularly strong and close relationships. Sometimes the anger was associated with practical things such as the diet, but more often it was diffused. Mr. Keoghan felt misunderstood in his concern about "what's going to happen...", and said very angrily "But you're always at the base of it - if something happened to me, how should you go on - you and Mary." Some husbands and wives "got mad" about the choices over his activities, either because "he takes risks" or "he worries too much" on her part, or because "she nags" or "she worries too much" from his point of view. Although it is slightly tangential to the main point about communication, the Langton family made an interesting suggestion which by implication adds to the general issue of sharing knowledge and experience. The first time they raised it, they put it in terms of the doctor at the hospital "setting aside an hour a week and have a kind of class where everyone (including wives) could listen." However, next time they spoke of this they suggested a centre or get-together - a club of some sort." While again they hoped that a doctor would give information, there was also within this concept, the possibility of mutual support and the exchange of experiences. This is something which they said they would very much have valued.

The discrepancies between the models was potentially a source of creativity and development, as it stimulated each patient's need to clarify his individual model and encouraged his passage through the process. At least one instance of institutionalised convalescence might in part be attributed

to insufficient tension between his and his wife's views with the result that progress stopped prematurely. On the other hand too much tension between the models could lead to a complete breakdown of communication with each failing to approach an understanding of the other's viewpoint. On the few occasions where this occurred and the husband had only the more distant models available, to use, his confidence in his own model was more tenuous than ever; the virtual absence, because it had been totally rejected, of the wife's model, highlighting the use that he could have made of it had there been some point of communication.

IV. SUMMARY.

This chapter brought the previous theoretical argument and data-analysis to focus onto the patients' own perceptions of their convalescent process and had maintained the theme of their own model in interaction with the models of their role-set. The discussion of the range of their activities was considered both in terms of general issues which affected it and then at a ^{micro-level} micro-level of discrete decisions. The patterns of progress through the convalescent stage which were demonstrated within the sample were suggested very tentatively, as no suggestions for comprehensive categorisation can yet be made. Finally, some of the factors which might either promote or inhibit the process were discussed.

8. CONCLUSIONS. * see footnote, page 211.

The research that has been reported in this thesis offers a contribution to extending the range of medical sociology in two ways. Firstly, it has focused onto an area that has been neglected in the past; attention to patient biography and behaviour has been concentrated onto the pre-diagnosis and 'being ill' stages to the exclusion of any interest in recovery. Where rehabilitation has been considered, its context has been formalised and institutional rather than the uninstitutionalised, spontaneous recovery that patients are expected to be able to achieve on their own. In this way, its substantive content has been different. Secondly, it has made a contribution by taking a different orientation to research methodology - one which has cut across the compartmentalisation of knowledge that is reflected in the literature, and instead has sought to range widely enough to understand the situations as the patients were experiencing them. Because the findings and the methodology are so totally inter-dependent, the theory that has been proposed could not have been generated from a differently orientated research project, nor can it be replicated except by further phenomenological research. In its own way, it has added a further demonstration of the value of a phenomenological approach.

I. Summary of Central Issues.

The central themes need only a brief recapitulation. Convalescence has been seen as a later stage of the passage from health - through illness - and back to health. As a transition, it is marked by ambiguity and contradictions which create confusion and this is worked through into the difficulty of choosing behaviour when there is no consensus about norms. By viewing each patient as interacting with his role-set, the influence of the role-set both in increasing contradictions and providing clarification is seen as a two-way transaction in which the patient makes use of the influences to meet his needs.

Four areas of significance can be drawn out from this summary of the theory. The first of these is a re-statement of the central importance of the interplay between the longitudinal and lateral dimensions. The longitudinal not only highlights the development of a sequence of stages but

emphasises the perceptual inter-relation of past - present - future in the actors' view of their situation. Any attempt to understand their perception of any particular time period is inadequate unless it takes account of the relation of that time period to others. This view clearly has implications for any study of process and transition, whatever the substantive area. The lateral dimension has stressed the breadth of the patients' social activity in two ways. It has viewed each patient in his social context, interacting with other people, and it has offered a model for understanding his choices about the range of his activities. This dimension offers a corrective to the tendency to study sick people within a vacuum, divorced from their social relationships and their 'normal' life. The significance of the longitudinal and lateral dimensions is only fully realised as the two are seen related to each other - a patient's perception of his position today on the longitudinal plane, and his expectation of his position next week or next month, being intimately bound up with the breadth of his experience.

In relation to this, some further comment needs to be made about the subject of values which has been referred to at intervals throughout the analysis. While it would be spurious to maintain that the research itself has been value-free, the orientation it has tried to maintain is that it is the individual's evaluation that is of importance. In this way, his view of what constitutes a life that is of acceptable quality to himself and how this is worked out in terms of daily activities is considered important, rather than an outsider's view of the features that comprise "valued social roles", in Pill and Jacob's (1974) sense. Not only is this consistent with the general methodological approach, but the specific focus on individual perception in this area indicates why broad classifications into value-based categories is inappropriate. For this reason, no attempt is made to depict "a cardiac invalid" or "poor adjustment", to select two terms that are frequently used, as these imply the outsider's judgement on the individual's behaviour. Where invalidity and adjustment are used in the text, these relate to the patients' own view of their behaviour and to the way they use such concepts in clarifying their attitudes and determining their activity.

Reference has been made in the earlier chapters to the need for further examination of the ways that individual evaluations of the future affect the present, thus pursuing the concept of related time sequences.

The second summarising point takes one area of this argument further. It refers back to Mair and Barnett's study (1962) that was discussed in chapter 2, which implied concepts of a 'good' patient who kept to medical advice, and a 'bad' patient who did not do so. The research has indicated new grounds for criticising these judgements. It has highlighted the impossibility of implementing in every-day life the generalised and contradictory advice that was given by doctors. In order to try to make sense of it, particular pieces of advice were perceived and interpreted within the patients' over-all understanding of their illness, so that even those who were "trying hard to get it right" were likely to operate on a model which was at variance with the medical model. While recognising that doctors can only be specific up to a certain point, more weight must be given to the difficulties that they unintentionally create for patients through the vague and contradictory messages that they convey. Further discussion of this can be held over until the final section.

The third area of significance concerns the need to establish the relationship between the general patterns that may be depicted and the specifics of detailed actions. Reference can be made again to Schutz's (1967) case for "constructs of the second degree, namely, constructs of constructs made by the actors on the social scene." The constructs built by the patient-actors have been seen to be built from, and worked out in, the apparently minute detail of their experience and lives. At first sight, the detail that has been used as illustrations throughout the thesis may seem trivial, but it is argued that it is of such detail that every-day lives are composed. This was the material from which the patients had to construct meaning and through which they had to work out their understanding. A study which ignores the common-place and undramatic aspects of life cannot reflect life as people lead it. Yet it would be inadequate to stop short with the detail, unless it can be carried through into "second degree

constructs." The inter-leaving of theory and data throughout this thesis has sought to draw out this interconnection between the 'macro-' elements of theory, such as status position, and the 'micro-' details of some of the data, such as a decision as to whether to do the wedding. This range of levels of generality is inevitable if the "actors' constructs" are to be presented in order to demonstrate the means by which the "second degree constructs" have been created. By balancing and relating these levels throughout the thesis, this implication of a phenomenological orientation has been worked out in practice.

The fourth area to which attention may now be drawn again, concerns the dynamic and creativity of any situation which can accurately be termed a process. In any study of a changing, developing situation, whatever its substantive area, the means of maintaining momentum and, conversely, the factors which may inhibit it must be investigated. Two aspects of this have been referred to in this study. Firstly, that communication may unintentionally inhibit movement, either because it contains intolerable contradictions or because it excludes emotive areas. Secondly, and very tentatively, that there may be an optimum degree of tension between the models of the convalescent process which enhance individual creativity; too much or too little tension correspondingly blocking movement. Studies of process must, therefore, be designed in such a way that they can 'catch' this dynamic.

II. ~~Indication~~ For Further Research.

Having drawn together some of the threads which have run through the thesis, I am now using these as a springboard from which to widen the discussion out. This section will consider some areas which need further research, and the final section will discuss some practical implications of the research.

Throughout the text, there have been some indications of the areas in which this study has raised research questions. These will now be drawn together and some further issues raised.

It has already been stressed that the theory is so intimately bound up with the research methodology that the study could only be replicated by

research with a similar orientation. However, this can now be qualified in two ways. Firstly, that having this 'map' of a previously uncharted area, future studies could have more structure because they could start with some awareness as to what they were looking for. Secondly, that certain comparisons would enrich it. Three areas of comparative study can be suggested.

The first of these would be to study a similar patient group in another hospital. This would make it possible to assess, for instance, the effects of different policies of patient care. The distinctive features of the care that this sample of patients experienced were described in chapter 3, and, of these, two points merit recapitulation. These were that all the patients passed through the specialised Coronary Care Unit, and, during their time in hospital, experienced a change in the doctor primarily in charge of them. An additional point, to which attention has not been drawn earlier, was the hospital policy of allowing visitors from 11 o'clock in the morning until half past eight in the evening. A study which reflected a different policy about visitors might indicate a different balance in the significance of visitors from outside the hospital vis a vis relationships within it.

Comparisons could also be made, as was indicated in chapter 2, through studies of other medical conditions. Comparative research of this kind if based on a similar theoretical orientation, would develop the theory of convalescence that has been proposed here by clarifying which aspects of it may stand as formal theory, and which are substantive to myocardial infarction only. Two such areas which would need clarification are the implications of 'common-wisdom' about heart attacks, and the place of anxiety/confidence in the recovery process when the risk of recurrence and death is known to exist. In similar vein, such studies might indicate how specific to cardiac disease are the patients' perceptions of the amount of exertion required to carry out individual tasks.

Thirdly, in addition to comparisons with other hospitals and other medical situations, this research also invites comparison with research into the process of resolution of non-medical crises. To date, this can only be extremely speculative as the parallels only exist conceptually, and have not

been tested. If this study were, in time, to encourage this kind of research, the way might be opened for the development of much needed general theory of crisis resolution.

If a study similar to this one was to be repeated with a larger sample, two themes would merit more detailed attention. One of these could look further into the patterns of progress, which were tentatively proposed in chapter 7. The other could consider in more detail the variable 'end of convalescence'. This would demand an extension to the time-scale of the research, so that some patients could be followed through a longer period until they perceived the 'end of convalescence' themselves.

These areas for future research that have been outlined so far all constitute feasible small-scale projects. However, two research needs remain to be discussed, both of which present major methodological problems, but which are important as either might lead to a refinement or challenge to my theory about convalescence. The first of these concerns the ways that the process of convalescence was accomplished (even if not finally ended) by the 'refusers' - those patients who did not want to take part in the research. It was noted in chapter 1 that refusal was not random and that the 'refusers' showed early and extreme forms of denial. It can be assumed that this initial response to their situation may well have led into very different patterns of resolving the uncertainties of convalescence from those used by the respondents. While it is true that some types of research and the form in which it is presented might secure the participation of those who use denial so strongly, this would inevitably have to have a different kind of orientation. Research of the kind that I have done, would be impossible unless the respondents were genuinely willing to reflect on their experiences and then to share these with another person. It was exactly this kind of reflection that the 'refusers' did not wish to embark on. The argument thus runs - this kind of theory could only have been generated from this kind of methodology, but this kind of methodology excludes out one (at least) segment of its potential population. While the extent to which this qualifies the findings cannot be assessed, this should not be taken to mean

that it invalidates the theory for those who did take part. Indeed, it may by implication add some confirmation to it by emphasising the 'normality' of the processes that have been described, which were not distorted by identified 'pathology', as assessed by current social/medical values.

The second, insoluble, research need concerns the extent to which the research process may have modified the convalescent process. Further attention will be given in the final section to the 'helping' content of the research interviews, and the point has already been touched on when discussing interviewing as an aspect of research method in chapter 1. However, it needs to be mentioned in this context as well. At first sight it would seem possible to resolve this by having a control group who would only be interviewed at the end of the research period. However, further consideration indicates that this would be unsatisfactory for comparison, for two reasons. Firstly, that the processes that they would have been through during their convalescence would have faded from their memory and would have been reinterpreted with the passage of time. Secondly, that the kind of information they could be expected to give would be qualitatively very different as they would be giving it 'cold' to an unknown person, rather than to someone they had learnt to trust within a known and growing relationship.

While it would seem possible to meet some aspects of this latter point by an independent researcher investigating the patients' reactions to taking part in the research - in a similar way to Mayer and Timms' (1970) study of social work clients - in itself this would not resolve the dilemma, as the patients would not be able to compare recovery from that particular illness with and without research intervention.

Only one point remains to be made on this subject; during the research on which I have been reporting, I was conscious of the possibility that I might distort the spontaneous process and I therefore took pains to minimise this. This in the main took the form of refraining from the kind of questions that the patients might have understood as challenges to their attitudes or behaviour. Because they were so unsure and, as has been indicated, were using the models of convalescence that were available to them, any definitive

position that I had taken could have been interpreted by them as 'the researcher's model of convalescence'.

III. Practical Implications.

Considering the extent and complexity of the problems surrounding convalescence that have been discussed in this thesis, it may seem remarkable that the patients accomplished the process with such apparent success. Yet this should not be taken to mean that, having studied the process, one can opt out with satisfaction. This concluding section, therefore, considers some of the ways in which this new understanding of convalescence could promote changes which could ease the passage for future patients. In doing this, the discussion will move through some general issues to aspects which relate to doctors and their patients, and will conclude with a few comments about the implications for social work practice.

Any reasoned proposals for change must, in the first place distinguish between those things which can be changed and those which cannot. For instance, the structural features of convalescence, such as its transitional and marginal status, would seem to be inevitable because of the very nature of recovery as a process during which physical health requires time to improve. Clinically, therefore, some ambiguity is inevitable. This thesis, though, has shown that ambiguity is widespread and far-reaching, and convalescence is very largely a social process. Contemporary social attitudes, values and definitions concerning health themselves make convalescence ambiguous, and may therefore have to be accepted as moderately stable and unchangeable. The extent of the ambiguity experienced by these patients should not, however, be so easily accepted. While it might be argued that it may be functional in ensuring that the patients observe limits on their activities while they recover, an orientation which considers their perception must view it as problematic.

Considering firstly the potential medical contribution towards reducing uncertainty and contradictions, there would seem to be a major point with secondary implications. The more fundamental point concerns the lack of clarity conveyed by doctors as to how they classify myocardial infarction

and view its prognosis. Reference may be made again to Watsons' schema, which was outlined in chapter 2, and Friedson's analysis of types of deviance, which was discussed in chapter 6. On both these occasions, it was noted that doctors' reported comments to patients reflected contradictions about its classification and outcome. Clearly, where there is clinical uncertainty, it would be futile to press for ungrounded definitive statements. Nor can one hope to hasten the progress of medical science by hortatory sociological reports. Yet the clear impression remains that the doctors' reported comments were more obscure than they intended them to be. One might question whether this resulted to some extent from the doctors' anxiety about committing themselves to clear statements which the patients could understand and act on, knowing that later events might prove them wrong.

A subsidiary point is closely related to this. On many occasions throughout the text of this thesis reference has been made to the uncertainty experienced by the patients as a result of the recurrence of pain. For many of them, this occurred for the first time while they were still in hospital, at a time when they could have been inducted into an understanding and management of this feature of their illness. However, they learnt little, and the staffs' attempts to reassure them without meaningful explanation added to their confusion. The one patient whose G.P. gave him specific criteria by which he could distinguish dangerous from non-dangerous pain was very greatly helped by this. One must therefore question whether similar criteria might not have been offered to other patients with equally helpful results.

It has become a common-place, when speaking critically about the medical profession, to suggest that more education of medical students in the social sciences would solve all the problems. However, this may easily be trite and over-^{sim}simplified. In view of the dilemmas experienced by these patients, both within the whole hospital setting and in communication with doctors and nurses, it is argued that it is not more social science education that is required but rather a different kind of education. This study has focused on the patients' perceptions and the meanings that they extracted from their situations. This takes the point beyond the difficulties inherent in what

doctors intend to convey, to the interpretations given by patients to non-verbal as well as to verbal interactions. Significant medical education could, therefore, alert doctors to this awareness that patients are interpreting and extracting meaning, even from things that the staff may consider inconsequential. To take the point further, education should sensitise doctors to the fact that patients may perceive communication to have a meaning which is not what the doctor intended, because they understand it in the context of their other perceptions. This kind of orientation towards communication, it is suggested, could have eased many of the difficulties that the patients experienced.

An additional subsidiary point which may be made in this context of the implications for the medical profession, is very closely allied to those that have already been outlined. This concerns the new light shed by this research on the concept of the 'bad' patient, who 'does not follow medical advice'. Once the source of their confusions about the nature of their illness, their future health and the regime that they should follow is understood, the reasons for 'deviant' behaviour may be seen to lie elsewhere than their own 'refusal to co-operate'.

In considering next the patients themselves, it must be recognised that they were generally reluctant to ask the doctors to clarify the issues they found so contradictory. Because their need for information was so great, they tended to turn for it to any source that was available, with inadequate grounds for assessing its credibility. While an increase in authoritative literature might be of use to some patients - for instance leaflets might be distributed through a society such as the British Heart Foundation - this still would not really meet the needs that these patients experienced. Any general literature would have to be couched in broad terms so that it was applicable to both a range of severity of the heart attacks and also to allow for any clinical complications such as angina. Such broad statements would be likely to contribute little to what the patients learnt from their own doctor. If the theme which has run through this thesis is brought into the present discussion, what the patients seemed to want was clarity about the

implications of their own doctor's model of convalescence which would be formulated in the light of their own individual medical condition.

This need to make the model specific is strengthened by the observation that has been made that many of the models of cardiac convalescence with which the patients interacted were based on an outmoded concept of coronary disease. The variety of conceptualisations which can co-exist during a period of rapid change in medical practice may not only mean that two doctors are implementing different policies, but that a doctor and the other units of his patients's role-set are likely to be greatly at variance. The potential existence of these discrepancies re-emphasises the patients' need for real clarity about their own doctors' model.

Following from the patients' needs over obtaining intelligible information one may turn to the need that they demonstrated for support both in tolerating the upheaval of the crisis and in resolving the complexities of convalescence. Attention was drawn in chapter 3 to the significance of the ward group and the use that was made of the interaction between the patients. This happened spontaneously and was created by the patients themselves, being the basis for the development of the 'cardiac culture'. If one assumes that it was experienced as helpful by the patients, which is certainly the impression that they gave, then this suggests the potential for using the group situation to even greater effect. Regular and semi-formalised group discussions, led perhaps jointly by a doctor, a nurse and a social worker, could provide a fruitful means of conveying information and preparing for the future. Within a small group who seemed to be spontaneously frank with each other about the details of their illnesses, it would be possible to relate the general topics raised in such discussions to individual patients.

It may be remembered that one patient and his wife made some detailed suggestions concerning such sources of support. There were two aspects to their proposals; firstly that the doctors should conduct a 'class' for the wives of the patients while they were still in hospital; secondly, that there should be a 'club' for those who were in the process of recovering. Both of these suggestions contain two elements, namely, the need for authoritative

information and the value of support from others sharing a similar experience. Having noted the significance both of the wives and the 'cardiac wise' in shaping the patients' models of convalescence, such groups could be effective in increasing optimum consensus and confidence.

While it is suggested that group support could be effective in achieving certain aims, the need of some patients and their wives for individual help must also be considered. A discussion of this refers again to the features of these research interviews which have already been outlined. To recapitulate this briefly, my experience as a medical social worker was initially an embarrassment to me even though it had been the means by which I had gained access to the patients at such an early stage of their illness. However, my conflicts over my two roles were resolved as I became convinced that it was ethically right to 'give' concern, support and involvement in return for what the patients gave me, apart from the fact that it was functional in increasing the frankness with which they talked. None of the patients were told, though, that I had been a social worker, although several of them assumed this. The relevance of this restatement to the present discussion is that I had access to interviewing people in a crisis situation who had not been defined by the usual referrers as needing social work help. Because I was able to offer support and 'therapeutic listening' where this was needed, I was in a position to be able to assess the use that they could have made of social work help. All the Full Series patients said that, to a greater or lesser degree, they valued the opportunity to talk of their views to someone who followed them through the whole experience. Some of the Withdrawers indicated the same attitudes. Those who expressed this with the greatest emphasis either had long-standing relationship difficulties within the family, experienced acute anxiety or depression or found the process of convalescence itself extremely conflicting. They valued the opportunity to talk to an outsider.

There are two aspects of this on which I would like to comment. Firstly, that in the current pressure on Social Services Departments, priority in the intake of new cases may understandably be given to such dramatic and outwardly

identifiable problems such as homelessness or children needing care. When man-power resources are stretched to their limits, attempts are not made to seek referrals of potential clients with intangible problems who can be assumed to be able to 'get by' and cope on their own. As it has been said before, none of the research patients had practical or material problems which they could not resolve on their own, and it is therefore not surprising in these circumstances that social work help was not requested. Yet the observations above indicate that many of them could make good use of help, and in some cases needed it on an emotional level. By implication, this underlines the need for the allocation of social work resources to take account of human needs which are not presented as practical and urgent problems.

My second comment reflects on the often uneasy relationships that can be found in social-work-within-research and research-within-social-work. The role tension that I experienced in the early days of the research may be seen as a reflection of the assumed dichotomy between the two spheres of activity. That this dilemma is shared with other professionals who engage in research is indicated in studies such as Parkes' (1972) work with the bereaved. He writes (p.26) "At the outset I had some misgivings about the entire project. It was not my wish to intrude upon private grief and I was quite prepared to abandon the study if it seemed that my questions were going to cause unnecessary pain. In fact, discussion of the events leading up to the husband's death and the widow's reaction to them did cause pain, and it was quite usual for widows to break down and cry at some time during our first interview; but with only one exception they did not regard this as a harmful experience. On the contrary, the majority seemed very grateful for the opportunity to talk freely about the disturbing problems and feelings that preoccupied them....Once she found that I was not going to be embarrassed or upset by her grief she seemed to find the interview therapeutic." Parkes, who is a psychiatrist, would thus seem to have shared some of my own reservations and later experiences. His comments also highlight the need for the research worker who is investigating an emotive and highly sensitive area to have a sound training in recognising and responding to the signs of distress

in the respondents. For this, social workers should be well equipped. In a study such as the one I have done, it would have been potentially harmful had the researcher been a person without this kind of training. Perhaps social workers may be more ready to enter into research projects if such reassurances about the compatibility of the two functions are repeated more often, along with a clear statement of the issues and if they have supervision available.

This discussion of implications has sought to distinguish those features of convalescence which could be modified from those which are inherent to it. In suggesting ways in which the process could be eased, it is recognised that all the actors who have taken part in this study have wanted 'to get it right'. In spite of the difficulties that they experienced, the patients did, by one means or another, manage to find their way through the convalescence process. This, in itself, stands as a tribute to all those who took any part in it.

* Footnote to 'Conclusions' on page 198.

It is recognised that the term conclusions, when used in its strict sense, concerns discussion of areas which arise directly from the research and can be inferred from the data that has been presented. In the case of this research, this relates to the perceptions of the patients and their wives.

In some areas, this chapter goes beyond a discussion of direct inference. It will be remembered, for instance, that no interviews were held with doctors or nurses and that their actions were reported second-hand. Such discussions draw on other sources such as observation, common sense and social work experience and may be viewed as potential topics for future research. This broader base to some arguments does not, it is acknowledged, have the same inseparable relation to the empirical data as has the central theory.

APPENDICES.

I - IV Documents relating to research method.

1. Specimen page of diary completed by patients.
2. Medical questionnaire.
3. Letter to wives requesting their participation.
4. Notification to consultants re patients forming sample.

5. Summary of interviews with Mr. and Mrs. Jessop.

Appendix I

Diary for.....

Name:

1. Who visited you today?

a) Who were they
(relationship, not name)

b) How long did they stay

| | |
|----------|-------|
| 1) | |
| 2) | |
| 3) | |
| 4) | |
| 5) | |

(Please bracket together any visitors who came as a group)

2. What did you talk about most with your visitors?

- your health or treatment.....
- things that are happening in the hospital.....
- things at home.....
- things at work.....
- the future.....
- something else (please specify if you can).....

(Please number from 1 for the most discussed - to 6 for the least discussed.
Put a dash (-) for a subject that was not discussed)

3. Were any of these topics particularly important for you today?

Yes/No

If Yes, would you say briefly what it was.

4. Have you today received any:-

How many

Who from (relationship not name)

| | |
|------------------------------|-------|
| - Letters of cards..... | |
| - Gifts..... | |
| - Messages via visitors..... | |

5. Were you particularly pleased to receive any of these things? Yes/No.
If yes, would you say why -

6. Have you sent any letters, cards, or messages today? Yes/No.
If yes, who to?

.....
.....

7. Have you listened to the radio today? A lot/a little/ hardly at all/not at all.

8. Did you buy a newspaper today? Yes/No.
If yes, have you read it. A lot/a little/ hardly at all/not at all.

9. Have there been any changes in your health or treatment today?

10. What have you been thinking about most today?

Appendix 2.

Lanchester Polytechnic
Department of Applied Social
Studies
Priory Street
Coventry CV1 5FB

RESEARCH PROJECT.

re Mr.

At this early stage of his treatment, it seems that

Mr. 's Myocardial Infarction has been:-

| | | |
|----------|---|-------------------------------|
| Mild | } | please delete as appropriate. |
| Moderate | | |
| Severe | | |

Are there at present any features of his medical condition
which may complicate his recovery, of which I should be aware:-

Yes/No.

If Yes, could you please outline them briefly.

Thank you.

Would you please return this form in the attached envelope to:-

Miss S. McMillan,
Dept. of Applied Social Studies,
Lanchester Polytechnic,
Coventry.

Appendix 3.

Lanchester Polytechnic
Department of Applied Social Studies
Priory Street
Coventry CV1 5PB

Dear

By the time you receive this letter, you may have heard from your husband that I have talked with him to ask if he would be willing to take part in a piece of research that I am undertaking. He gave me his permission to write to you and I very much hope that you will be willing to allow me to come and talk with you.

My research is into what it means for a person and his family when he is admitted as a patient to the Coronary Care Unit as this must have many and varied kinds of implications. Everything that I am told will be treated in very strict confidence.

Although the hospital has given its permission for me to talk to your husband, a willingness to take part in the research project is completely voluntary on both his part and on yours.

I will see him on a few occasions during his stay in hospital and will be sure that our talks do not tire or strain him. I would also like to come to see you at home at a time which is convenient to you.

I very much hope that you will be willing to help me in this way.

Yours sincerely,

S. McMullen (Miss)

Lanchester Polytechnic
Priory Street
Coventry CV1 5FB

Research Project Sample

Re: Mr

I am writing to inform you that I am interviewing this patient and his wife in connection with my research project on patients in hospital with coronary thrombosis. This research, as you will know, has the approval of the Medical Division, the Medical Research Committee and the Hospital Management Committee.

If at any time during this patient's treatment you consider that there are medical factors which are contraindications to my continuing to interview him, please let me know immediately. I can be contacted by phone at Coventry 24166 extension 227 or at Coventry 458739.

Susan McMullen.

Appendix 5.

A full summary of the series of interviews with one respondent and his wife is attached for three reasons. Firstly, so that the artificial separation into time-periods, which was necessarily employed in the text as an aid to analysis, may be balanced by the longitudinal view of one family's experience. Secondly, it is a means to highlight the contradictions and inconsistencies within one experience, and at the same time to convey movement as the process develops. Thirdly, to indicate the kind of data from which theory has been generated. Annotations are kept very brief to avoid unnecessary interruption of the dialogue.

Mr. Jessop is not chosen for this study as a 'typical' respondent, as in a small sample with such heterogeneity this did not exist, but because he illustrates many of the themes central to the thesis. He had a well developed capacity to conceptualise and was highly articulate. The interviewing technique used in these interviews was more passive than with some other respondents, not only because it was difficult to interrupt his flow of words, but more significantly because he needed little prompting to talk in relevant areas and was neither very distressed nor depressed so as to need a supportive in-put from the interviewer.

Summary of interviews with Mr. Jesson.

Mr. George Jessop
aged 61
married
Occupation - panel beater
Housing - owner - occupier of terraced house

Medical information

Pain in evening of 19.3.74, with vomiting, which lasted all night

- he thought it was indigestion

- no previous history of pain

No previous medical history

Diagnosis - Myocardial infarction. (Classified as Moderate on severity scale)

Admitted to hospital 20.3.74

21.3.74. Intake interview. Very brief - to obtain his consent, after explaining research project.

22.3.74. 1st interview.

Agreement to use of tape recorder.

Interviewer:

Re-interpreted research, in terms of wanting to know about "what it is like for you - what it feels like - what the difficulties are about having a sudden illness like this...."

Him:

"....it's a sudden shock. It's the sudden shock to realise that you've been seriously ill - like now, I don't feel seriously ill now, but I've got to realise that I've been seriously ill. This is one of the things that takes a bit of grasping when you've been very strong and healthy and worked hard all your life - it suddenly hit you with a bump.

(Shaken view of health status and self-concept)

Int:

"Have you ever had an illness before?"

Him:

"I had pneumonia once, but nothing to really cause any problems - no more than the average person has....nothing. This is a different cup of tea, this is. It's difficult to realise that you've got to - when I do eventually get out of here - I've got to slow down."

(Predicted change for future)

Int: "Are you feeling that?"

Him: "Yes. The first thing I've done is I've packed up smoking. Mind you that was easy for me....that was the first thing I've done."

Int: "Did the doctors tell you to do that, or was it your own decision?"

Him: "Well, it was my own decision - he asked me if I smoked and I said 'Yes I do, but I'm not a heavy smoker'....I just thought - I've had this thing, and you're not allowed to smoke in here, so I might as well pack them up. I know I shall be better without them - if it helps me to get better quicker, so much the better."

(Change related to improving health)

His wife only smokes occasionally.

"I'm not rich, but I'm not poor - comfortable for a working man.... I own me own house and it's just me and me wife - I've had a reasonable job all me life, so if I wanted, I could take a couple of years off work and not have to worry about it financially. This is probably a bigger thing for a younger man rather than me. What I'm trying to say is - I wouldn't have no need to go on Social Security or something like that."

Int: "You could still be comfortable?"

Him: "I could for a couple of years or so - but with being active, I would find the time terribly boring doing nothing. I would want to find something - I wouldn't care what it was so long....I'd have to do something....I couldn't just sit down in a chair and read. I've been active all my life....I've always wanted to do something. Of course, bowls is a big hobby of mine, I'm a keen bowls player. All these things I've got to start thinking about - that I can't do them anymore for a bit."

(Change - Loss ? Permanence)

Int: "We could talk about that a bit more in a minute. With you saying that you're usually a very active person, I'm wondering what it feels like for you at the moment being in bed here?"

Him: "Terrible. Once the pain went, it started to get boring. When the pain was bad you didn't care what happened so long as you got rid of the pain - but once the pain has gone, laying here you feel all right. It's terribly boring when you've been used to doing something...."

(Illness measured by pain. Present uncertainty)

Int: "What do you feel about being linked up to the monitor?"

Him: "I don't know anything about it really - it doesn't bother me.... I didn't realise till the morning that I'd had a heart attack - I thought I'd got a bad bout of indigestion. I layed in bed from about 7 o'clock Friday night till I walked down to the doctor's about 11 o'clock next morning. Like indigestion, that's just how it catches you. I said to the wife 'If it had been indigestion, after a couple of hours, that would have shifted' - so I walked down to the doctor. He took one look at me and said 'You're very ill - get back to bed and I'll send for the specialist'. That was that. You suddenly find you're - you read these things in the paper, so-and-so collapsed in the street with a heart attack, and you don't think a thing about it - it's only when it hits you, that's when you start to think about it. It's like bereavement - it's a similar thing - until it hits at your own doorstep, you don't realise just what it entails. I didn't think it was a heart attack when I got the pain - I took some Rammies for indigestion."

(Difficulty in realising what had happened. Health behaviour and medical definition of the situation)

Int: "What did you do during the night?"

Him: "Oh, it was terrible. I could neither sit, stand nor lie to tell you the truth. I got up in the morning, and I didn't know what to do with myself."

Int: "Was your wife worried?"

Him: "Yes. She went and rung the doctor up. I then went down to the surgery. I walked there - mind you it's only two doors away - so it wasn't a big effort, but it was an effort - especially when you get in here, and you're not allowed to get out of bed. He sent me back home, and I went straight to bed and he sent for the specialist. Then he came himself, before the specialist arrived - he had a very urgent appointment in Birmingham, but he called in before the specialist. Then the specialist came, and tested me, and told me I'd had a heart attack and bunged me in here. It's a funny feeling, from being tiling the kitchen in the morning to being in bed with a heart attack now. It's the suddenness of it - it's like an accident somehow - but nevertheless, an accident is an accident - this is something more - you've got no premonition of it....That patient - he was in bed when his came on, it's his second one, he had one eight years ago."

(Appreciation of / dependence on doctors. Dislocation of usual life)

Int: "Looking back now, do you think there were some warning signs?"

Him: "Yes, there were some warning signs, but I didn't realise....Just like - I walk to work, some 3 or 400 yards from where I live - in the mornings, I'd stop once when I'd walked the first 100 yards, then I'd walk the second 100 yards and I'd have to stop, but after then I was all right. Now, I didn't have to do that when I came home at night. It was always in the morning, just like a bit of indigestion - that's what I put it down to, but ~~it~~ ^{it} stopped you. As soon as I told the doctor, he said 'You should have told me' I said 'Well, I've never been a chap for being away from work.' I became unemployed for the first time when I was 59 - I've never been used to being idle. I was redundant when the Bells crash came. I had a couple of months rest, but I've always been reasonably skilled, and it wasn't difficult to find a job. I've worked in a lot of towns - travelled from one town to another as a panel beater. I shouldn't be able to carry on with it."

(Usual values being challenged. Work change predicted)

His son and daughter-in-law arrived from Newcastle to visit him, so interview terminated.

Home visit to wife arranged for tomorrow.

24.3.74. Home visit to Mrs. Jesson.

A tiny house, crowded with possessions, and having a blazing fire creating a very homely atmosphere.

Int: Expressed my thanks that she had let me come, and re-explained the research to her. She agreed to the use of the tape-recorder.

Her: "I'm not a person what dwell on anything, - if it's gone the right way - so I take things in the stride a bit. I think that's why I'm so plump. Mind you it was a terrible shock really. But then, the men in his job and round about our age - you hear so much of it - you think 'Oh, he's never got the sheet-metal-worker's complaint - a weak heart.'"

Int: "Do they call it that?"

Her: "Well, they don't exactly call it that but there's so many what have it." She had been talking to a friend who told her that her husband's previous foreman has had a heart attack. Another man in the same trade has had two. "It's all chest work - bashing." She talked about what was involved in the job and the various kinds of firms he has worked for.

Int: "It can still be hard to realise that it has happened in the family."

Her: "Yes. Now I've got a brother-in-law, he's in the trade - he's got a - what do they call it - the shock has taken my memory away - he's got angina. He'd be about 57." No other relations have had it - "so it did come a bit of a shock, and as I said, it's took my ~~memory~~ away a little bit - the shock did, but I'm getting it back a little bit. I've got high blood pressure. For the first two days I had a terrible head all day long. I think it must have been the shock. It went off yesterday. You know, you're tensed. Well, you have so much to do and so much to think about. And I'd only got myself here then."

(Gradually opening up on her responses)

Int: "Were you doing more things than you would usually?"

Her: "Yes - because I had more running about to do. I didn't have the ordinary jobs to do - I had other jobs to do, like going up to the hospital and going down to the doctor's to tell him what somebody else had said and all that sort of thing. Not your ordinary jobs."

Int: "Have you gone on with the ordinary things, like looking after yourself and cooking meals?"

Her: "Doesn't eat much anyhow, because supposed to be on a diet. She will copy her husband's diet, and both will eat the same. "But the first two days George was in hospital I didn't have time to cook myself a meal. That's a funny thing to say - I just didn't have time." Got hungry and ate snacks. Now daughter-in-law has arrived, "that's different when you've got somebody to do it for you. She's got a baby - a boy of two and a half, and he's got to have his meals." Are eating regular meals now.

Int: "It's probably a relief if she's taken over those ordinary things."

Her: "Yes. It'll be all right now that you've settled yourself down. Once you've settled yourself down after those first few days, you're all right. You come out of your own regular jobs and get into those regular jobs. It's just like leaving work - because I got in such a routine that work just came natural to me and I retired last July, and I had to start all fresh routines. Now it's the same when you get one of these upsets - you've got to get yourself into another routine. I'm one for routines." Discussed her usual daily pattern. "Now I don't do any of that - I do the shopping when I can. I have to go up to the hospital by bus, and it's a long way from here."

(Disruption of normal social functioning)

Int: "How are they planning out visiting?"

Her: She goes in the afternoon - for about three hours. Gets someone else to go in the evening - "so that the time doesn't feel long for him." Tries to space them out "it doesn't tire him out." "The visiting is very nice - all day - it's better than those restricted

hours." She gets it organised.

(Protective aspect of 'mood-management':)

"That's just my trouble - I'm not bothered about the house, I'm not house-proud - but I must have things going routiney. I suppose it's because if I hadn't been in a routine, I'd have got in muddles. I was a waitress at work - I had to have a routine. Is that how you organise yourself?"

Int: "No! I get in muddles! "

Her: "It suits me, but sometimes people think you're a little bit bossy."

Int: "Does your husband like routines?"

Her: "No. I routine his life. He just lets me routine his life, and he fits in. He's so used to it now."

Int: "How do they sort out jobs and decisions between them?"

Her: "We do it between us" Were going to see son at Easter - she got him to go to find out about coaches. "That's all fallen through now, - they'll come here now. We do it between us. When I was at work and hadn't got time, he would do a little bit more of the organising and then sort of things. He usually does all the letter writing."

Int: "What about carrying the coals and doing the garden?"

Her: "I do those!....I love gardening, but it's his garden but I do it!" talked about what they grow. "We do it between us. But of course, I've got nothing else to do now. My life is so empty since I left work, even though I only worked part-time."

(Previous role-fit)

Int: "It was quite difficult to retire?"

Her: "Oh, it was. I met the public. I always saw someone I knew. Now I'm at home all the time. I've started to go down to Church and go to the Mothers' meeting. I used to be on the committee of the Townswomen's Guild, but I haven't started that again. I don't think I will, because the doctor said 'You must take things quieter'."

Int: Having husband at home more may change her feeling of being lonely?

Her: "I did use to miss him after he went back from the three-day-week."
She has always been one of a big family and had people around.
Comes from Suffolk - came to Coventry during the war.

(Possible gain from his illness)

Int: "How much contact have you had with your family while your husband has been ill?"

Her: Has two sisters living in Coventry - one is away at the moment.
"The other sister, she come up straight away. I couldn't let them know till the next day, and she come up straight away. She was making up beds while I was up at the hospital. She's a very good sister - she'll come and do anything."

(Help from extended family)

Int: "When were you able to let your son know?"

Her: "Oh, I phoned him - after the specialist came. I asked him - 'I've got a son in Newcastle, do you think I ought to let him know? Is it serious?' He says 'Oh yes, it is serious'." She went to hospital in the ambulance with him, and rang later when he was home from work. They came the next day - "they are good children." She and husband had been upset when they moved away from Coventry. Son will go back to work tomorrow, but "if his father was not mending he wouldn't have gone back, but being as his father is on the mend, he'll go back, and she'll stay nextweek. They they'll come home for Easter."

(Son's plans reflect perception of husband's health)

He'll be home by then, because he's moved off that machine (the monitor) tonight. They had a very bad case come in, and George was the one what they could move off - he was getting on the best. They moved another man off yesterday, but he had to go back on it again."

(Staffs' actions are significant)

Int: "Did you have any feelings about that?"

Her: "Yes I did. Now tonight I shall be a little bit anxious till I ring up in the morning to see what sort of a night he had. He's a little bit lonely in that room by himself, but I expect they'll soon put somebody else in. He looked such a poor little....I felt so sorry for him in that ward all on his own. He's a man what likes company, and he likes talking. He'll talk and talk and talk if you'll let him. It wasn't nerves, but he's a very active type of man. He's always been" Would walk miles. "I'm not so fond of walking. I've slowed down a lot since I've had high blood pressure. The doctor encouraged it - and the tablets I had to take, they quietened me down a bit."

Int: "Are you hoping that he's going to slow down a bit?"

Her: "He has slowed down. He has been doing less. Now I'm looking back, of course, you put it down to age. You don't think they're ill, if they've got nothing the matter with them. You just put it down to age, because I've slowed down a lot. He's had pneumonia and he's had the flu two or three times, and he's a little bit cheery."

Int: "Would you like him not to be as active and energetic after the heart attack, or do you imagine that things will get back to where they were before?"

Her: "No, I don't think they'll ever get back to where they were before. Because he was so active. He's slowed down a lot before he had this attack. I've known him sleep in till 9 o'clock in the morning when he was on those three-days, but I'd never known that before. You're not the same at 62 to what you are at 40."

Int: "Do you think though that after some months, he will be the same as he was, say, at Christmas?"

Her: "Yes. We had a quiet Christmas - we're not a couple to go out a lot - I don't like going out drinking, I'm content with the television and the papers and a bit of knitting. But yes, I think by the time July comes, we'll be back to normal like we were in our older days, but not in our younger days."

(Confusion between health status and age status)

She talked of their activities and their holidays in a chalet at Lowestoft. "We've not booked for this year, it's a good job we haven't, because I don't suppose we shall probably go anywhere."

"You can't tell. But I like having people around me."

(Expectation of change in usual life style)

Int: "Do you know the people around here?"

Her: "Oh yes, I know all the neighbours." She talked about them - very friendly - "we're a nice little community, though we're not ones to go in and out of houses. But like, Joan came in straight away, she says 'You just go, and I'll see to the house,' when the ambulance come." One neighbour been ill and been to the hospital a lot. "I don't like to - he's said he'll drive me to the hospital, but I feel Oh that poor chap he's been going there all that while - I'll go on the bus. I don't think I'll ever ask, I'll make my own way. I'm a little bit independent that way." Was upset when a neighbour died - "we've lived here thirty years. I should hate to move - to go among strangers."

(Ambivalence in using help offered by neighbours)

Int: Thanked her for her time and talked about future series of interviews.

24.3.74. 2nd Interview with Mr. Jessop.

Now in the second stage of the C.G.U.

Int: I asked about the change of wards.

Him: "It was a bit of an exhilarating feeling. It was a surprise really - it happened a bit quick. It happened for two reasons - one that I was getting better, or lets put it another way - there was an urgent patient come in and I was one of the other three patients who at that time was progressing the most favourable. So that gives you a boost. I felt hungry last night for the first time since I've been in here, and I ate more food than I'd ordered. It's an - exhilarating feeling. You see, illness is part physical part mental

at least I think. I mean, when you're in here, the biggest fear you've got is fear of the unknown - what they're going to do to you. When you get in here, you realize that whatever they do to you isn't as much as what they was going to do if you was still in there. It's a psychological thing I suppose."

Int: "Is that to do with the fact that there's less equipment in here, or more than that?"

Him: "You see, that place there you must be in there three days to see if your pulse is running reasonable. Once they see that - you see in there, you're under the eagle eye all the while. Now in here, we just see the odd nurse. We've got a bell if we want. But we're not under the eagle eye, because we're not as ill as we was when we was in there. That's the big thing about it. Did you find out where I live?"

(Two ways of assessing progress)

Int: "I saw your wife. She told me you were alone in this ward."

Him: "I was. They brought him in about 5 o'clock. He was then in a similar position to what I had been in - he was the most forward in there, and there was people more seriously ill, and so they brought him here. Which is far nicer - you've got time to imagine too many pains when you're laying here on your own - even a small pain exaggerates itself, because somebody said this morning when we was talking - 'the difference between having a heart attack and having an illness with an operation is that one is a cure and the other is a transitory (sic) hope when it's cured - it could come again' - when, you don't know - but if you've had appendicitis and had it out, it can't come back no more. But this is a different cup of tea. But as he said when you first come round to here - of course he'd had one before, he said 'Every little pain you think it's something more serious than what it is.'"

(Doubts about present, future health)

Int: "Do you find yourself thinking about that?"

Hin: "Yes, I do really. I find myself thinking about how I shall feel when I go out of here, as regards walking down the street or whatever - obviously, you know you've got to take your time whatever you do. I shall have to give up alcohol, and I've already packed up smoking, so - mind you, alcohol is easily given up. According to some sources of information, it's better for you; I suppose it adds up - if you're not allowed it in here - it's probably just as well if you don't have it when you get out.

(Any necessary change can be accepted)

I'm feeling better - it's a big thing - when you're in here, you can have a laugh with the nurses because you feel in that frame of mind. Whereas when you're ill, you don't want to know anybody.

(Subjective assessment of improved health)

I've been sitting thinking this morning about what I shall do when I come out. At the moment, I've got two problems. My daughter-in-law isn't very happy up north - very homesick - and my son's a professional engineer, and he's trying to move down in the company he works for to nearer here. All these things take money. The fact that I don't think I'll do a lot more work - in the sense of the salary that I've been used to - I'm inclined to think that if she's homesick and I've got no ties in Coventry, if he's got to move to another place, we could pack up and all go together. This is the sort of thing that's been going through my mind. He's coming up this afternoon 'cos he goes away this afternoon, my son does, and I was going to mention it to him - partly to give him some grounds for thought, and partly that I'm not committed now to finding a job. Apart from something in the £20 a week class - not the work I'm used to. Because of the boredom, I couldn't stay around the house all day long - I'll have to find something. Just if it was enough for me and the wife to tick over - we don't live in a mansion, but it's ours and it's paid for - all we need is food

and rates. I don't run a car, because I don't like one, - my requirements are not as much as for a younger man - it must be a far bigger worry to a younger man, whose family is still a liability to him. Because I've worked longer than them and have got less time to do. The only thing about it for me would be that I'm - from being a skilled person to drop down to doing something which was thoroughly beneath your capabilities."

(Prediction of radical changes in future)

Int: "You sound like the kind of person that takes a lot of pride in your skills."

Him: "Oh, yes. I always have done. I've worked on every aeroplane that's been built in this country, and I was at Rolls Royce." He talked about his working life and the high standards that were expected. "They called me Fiddler at work because I used to fiddle about till it was right...I always had a pride in my craft." Has done some wrought-iron work for his son's house which he was very proud of - "it took me weeks and weeks and weeks, but when I'd done it I said 'I made that'" Many young people don't think this way. "I shall probably find some hobby in the shed to use my skill." Talked of other things he has made. Compared it to the satisfaction an artist must have - but envies them. Chatted about the various planes he has worked on. "The first time I worked under an inspector, I clouted him - I didn't know anything about it. I came out of a very small work shop, and had never been used to anyone inspecting my work - when it was right I just put it down and that was it. We had wards...." Has moved around a lot. Been in Coventry for 30 years and likes it - was surprised when his son left. Would have a lot of regrets about moving away - "even though I probably shan't be able to play bowls, I also have a lot to do with running the club - I would miss that and the friends I have made."

Int: "When you say that you're thinking you may not be able to go on doing it, are you really thinking quite seriously that you may not be able to?"

Him: "Yes, I'm thinking that, because having played it I know the effort involved. It's not the same game as you've probably seen." He explained the difference between Crown bowls which he plays and the other kind. He likes the kind of people that play it. It's where he has his friends.

(Change will have to be accepted, even if 'Loss' is high)

He drank his tea, but said he didn't enjoy it because it had no sugar - "It's a matter of will-power. It's a good thing I've got will-power, because once or twice there's been sugar on the tray! You could slip one in, but there again it's the unknown, you don't know if you're going to be doing right by doing it or doing wrong. Or you could get the mares into trouble by putting sugar on the tray when they shouldn't."

(Uncertainty causes worry)

"I've had a good life - I've worked hard and had a good missus and family. We're one big family - they're there when you....I've had a fellow come up here yesterday morning from work - I've only had a drink with him a couple of times, I never thought we were very friendly, but he came in here with forty cigarettes and about a dozen oranges and apples - people that you don't think will do those sort of things. This is when you learn to appreciate there's a hell of a lot of good people, as well as bad. I've tried to live that way - to do a good turn." Never kept a job as foreman, because he was on the workers' side rather than the management's - is different from his son.

(Meaningful contact with 'others')

Int: What had he thought about son's journey from Newcastle to see him?

Him: He thought daughter-in-law was glad on an excuse to come to Coventry "because when she rang them up she told them there was no immediate

danger or anything - it wouldn't have made any difference if they couldn't come - apart from being glad to see me. It's a hell of a long way to come." Son has a good job, but ~~daughter-in-law~~ hasn't settled. He knows it is difficult to leave home - he had a bad time and got very homesick.

(Doesn't see son's journey as indication of seriousness of his illness)

Int: "Have there been situations before when you have had to be away from your wife?"

Him: "Yes, many times." When he moved jobs, he went first and got a house and she followed later. Had a chequered work history - often got the sack for no known reason. Came to Coventry in the war - not called up because ^{his} job was a reserved occupation. Very hard work, but glad he wasn't in the army. Anecdotes went on for some while until he realised he was rambling on. "Anyway, I'm a lot better than when you came the last time. I'll tell you one thing - they're pretty good in a lot of ways. When you ask them 'Am I doing all right' even though you know you are better than you was - they tell you."

(Needing medical confirmation of his improvement)

Int: "And you feel you can ask?"

Him: "Yes. They're very nice - whatever colour or whatever they are, they're very nice indeed."

Int: "Have they said yet when you will be able to start getting out of bed?"

Him: "No. I've been out of bed to use a commode - I'm allowed to do that. But when we're allowed to walk to the toilet, I couldn't tell you. I guess I won't see anybody today (Sunday), but the big noises will be around tomorrow. He's very nice. He doesn't look no more a specialist than fly - he looks like an Oxford or Cambridge rugby fan going to a rugby match. That's how he struck me - a smashing fellow to talk to, and he knows his job - you can tell."

(Positive about medical staff)

Int: I gave him the diary (not done in first interview, because it was out short) and explained. He agreed to complete it.

I arranged to see him again in a few days. He said talking helped to pass the time.

28.3.74 3rd Interview with Mr. Jessen.

He was now in one of the general medical wards.

Int: I enquired how he was - he said he felt fine.

Him: "They said this morning, I might be going home Sunday (31st). I haven't seen you to tell you, but they come round the day before yesterday, and I asked them if I could get up and sit on the side of the bed. He said yes, but only for a minute or two. He said 'I'll see you again after a couple of days'. This morning, he checked me over and asked me this and that. So he said I could get up for a little while today and probably go home on Sunday. So I've been sitting out of bed....so I was more than pleased."

Int: "So far you have just sat?"

Him: "I've only sat. I've got got any fears of walking round because, I've been on my feet, and, though I couldn't push a bus round, I didn't feel too bad at all. So I'm not anticipating any trouble. Of course, you've got to do as what they tell you is the main essential, I think they've got a bit of a system here by which you get out and sit for about three quarters of an hour one day, then you're allowed to walk round the bed the next, and then as far as the toilet the next - it's a sort of gradual process like.

(Reliance on medically defined stages of progress)

I'm not anticipating any trouble, but I feel, well....the first thing I knew about feeling well was when I started to eat - I thought to myself - hungry - I must be getting better. That's the first reaction to hunger in hospital, it's obvious it goes synonymous with getting better - anyhow it struck me like that. Then feeling your feet.

(Subjective progress)

There's three of us was all in the same ward - now one came to tell us he's going home tomorrow. Well he was up on his feet yesterday, and he's been walking up and down here today. So we've all kept a little sort of progress report. Actually, it's been like a horse race, really - I've been in the front once or twice; he was in the lead first, then he fell back - it's been between the three of us - competing. It's funny thing really, but that's how it's worked out. It's a nice feeling, though, to feel better - that's the top and bottom, feeling better.

(Use of 'cardiac wise' to gauge own progress)

And being able to have a laugh." Has been used as a patient for nurses taking their exams. - "you felt well enough to be able to take an interest in them. The first or second day you was in, you couldn't have been interested. All these things tell you you're getting better."

Int: "Have you begun to feel interested in things outside the hospital?"

Him: "Oh yes. I had my bowling team here last night, anyhow four or five."

Int: "How did that feel, if they were talking about the club?"

Him: "Well, they wouldn't let you feel out of it - you're still part of it even though you couldn't play. They would make sure you was involved in the thing itself. I've got some very good friends. They sent me a card with bowls on it - someone must have searched for that!" He talked of his other cards - some from people he doesn't know very well.

Int: "How do you think they had heard you were ill?"

Him: "Well, I'm rather well known in different circles - my trade and the bowling world. They're interested to see you getting better - they're interested in you as a person. This is the difference between poor people and rich, they're not interested in you for what you're going to be able to do for them - not because you're going to be able to do anyone a favour - they either like you as a person

or you've done them some good turns over the years, and they haven't forgotten it." Can pick up friendships after a gap. News travels in his trade even between factories - every sheet metal worker knows he's ill - "a grapevine."

Int: Some people feel very out of it in hospital.

Him: He reads paper to keep in touch with what is happening, and friends tell him. One of the volunteers was a sheet metal worker and already knew of him and his illness. The other patients all have interests and they talk a lot. "This is what makes you better - this is what takes your mind off any niggly pain. My worse night was the night I was on me own....I should never want to be in a private ward, because I'm a person that likes company, and I've never found it difficult to make friends. That was my worst night, and I rather imagined the pains was coming back, and you didn't really sleep - about two o'clock of the morning, you tend to wake up. You've got imaginary illnesses then - but if you're talking to somebody, you haven't."

(Value of support from others)

Int: "Do you remember when you last felt a pain?"

Him: "Well, I've never had a pain since they took me in the ward that first day. It was an imaginary pain, that stopped when....nerves have an effect. You see, when you come into hospital with something like this, and you've never had it before, it's the unknown that you're afraid of, not the known, it's the unknown. When you get about seven or eight doctors all standing around your bed all talking in abbreviations, you tend to get a bit nervous, like, but as soon as I went down to this ward, I was as right as rain.

(Source of anxieties)

Of course, psychologically I knew that once they moved me down here that I was getting better. That was one of the biggest things - that I knew I was getting better. Of course, they take you off them monitor things - so when I came down here, I thought well I must

be getting - well I knew I was getting better - but the further you get away from there the better you're getting. You don't go three parts across the hospital, if they're going to wheel you back again. That's my way of thinking about it.

(Staffs' actions more significant than subjective definitions of progress)

We've just been discussing now with my wife, and that was her sister with her, about the diet and how I've got to take care when I get home. He asked me if I smoked, this morning. I said 'Well I did till I came in here. But I haven't had one since then, and I don't intend to have any more' So he said 'That's good.'

Int: Is diet sorted out?

Him: "I don't think I'm really on a serious diet. I'm on a thousand calories, and to me I could live comfortable on a thousand calories a day. It's only that they don't want me to put on weight." He is only a little over-weight. "It's not going to be a problem. My wife, she'll have to slim as well - it'll do her good." Will only miss sugar. "I think it's a good thing this has happened to me - it'll slow me down. I think I could have carried on and then had a real bump without any chance. This is going to teach me a lesson to slow down. I have worked hard all my life and never thought nothing about hard work, I haven't lived a riotous life, but I haven't lived like a man....I've always liked a drink - a social drink, but it's been quite an interesting experience. All I'm looking forward to now is going home and seeing how I get on once I'm at home."

(Gain - Threat - Value)

Int: I arranged to see him again here, or at home.

Him: "I'll probably be able to give you more information by then than I can now. I shall know how I felt to get out of here - the things what's happened in here I've writ down or I can easily remember. We had this remarkable fellow in here - he'd had five heart attacks and when he went out he was still going to carry on living the same way, as if he's got no fear of tomorrow - I could tell you more

about these type of people.

(Using other cardiac patients to confirm his own path)

What was the amazing part of this - can I bring religion into this? - I'm not religious, though I was brought up to be - this friend of mine had brought me more fruit than I could eat - he was a catholic. This fellow (a patient) was doing real good in the world, helping everybody and making them laugh, now he was a catholic and yet he was also an alcoholic. It struck me that it was funny. I was brought up with no drinking, gambling or smoking, and church three times a day on a Sunday - that's why I've never been since. Everybody loved this fellow - he was a very remarkable man. This taught me that there must be good and bad in everybody."

31.3.74. 4th Interview with Mr. Jessop

(On a different ward)

Him: "This is the confusing part about all this - the continual moving. This is something that I think they should tell you why. All of a sudden you've been whipped round the corridor."

Int: "How much warning did you get?"

Him: "Well they just come in - 'Mr. Jessop?' Just like that. My wife had brought my clothes in case I might have gone home. Of course, you think what have they moved me for if I could recuperate just as well in there - they've obviously got their reasons, but a little bit of enlightenment wouldn't hurt. They could say 'Well....' You see when you're in hospital, you always need something to boost your ego - something to make you think you're nearer the front door, even if you're not. They could just as easily have said to me 'We're moving you round here because....' I think there's not so much nursing attention on this particular ward. This is only what I think. That's as much as I know about it.

(Staffs' actions now seen incoherent)

So instead of being able to say to my wife 'I'll be out tomorrow, or....' You see, they told me last week that Sunday I would be

out. I was setting my hopes on that. But I knew yesterday, seeing as I never see a doctor yesterday - I asked the Sister last night if I was going out today. She said 'There's nothing written down about it'. Anyway, I done rather an unfortunate thing last night - I fright myself a little bit. I got my mate to push me up to see Match of the Day on television. I felt O.K. and I'd come back, and I thought I'd walk to the toilet. About an hour previous, I'd ate a banana - Well bananas are right indigestible if they're not ripe. Well, I had a pain last night at about quarter past eleven,"

(Worried by pain. Attempt to find rational reason for it)

Int: "A chest pain?"

Em: "Yes. It frightened me a little. But I lay here for about ten minutes and it went off and then I had a beautiful sleep. So what or why, I don't know. I told the Sister, mind. I think you've got to tell these people the truth when you're in here or you're wasting everybody's time. It's no good saying you didn't have a pain when you did - so I told her. Whether that's anything to do with me being whipped round here or not, I don't know.

(Worries about move and pain interact)

But I'm not back to square one because I'm a lot better than what I was, but nevertheless....There's another thing about this, I've made some lovely friends in this hospital since I've been here. Now I've got to start all over again. It was a very happy group - therapeutic I would call it - and we'd all got our own confidences with each other, and all of a sudden you're uprooted. I wouldn't know if it's good for you. Fortunately for me I'm a good mixer - I soon.... within an hour I shall know half these peoples' backgrounds and they'll know mine....I'm just lying here taking no notice at the moment. I was just about to do my diary - nothing much happened yesterday. I'm going to put in about an alcoholic who palled up with me - he told me how it started."

(Importance of ward group)

Int: "Did you feel well enough to cope with that?"

Him: "If you was ill you'd only want to tell him to clear off - you've only got troubles of you're own then."

(Sign of improvement)

People always seem to talk to him - he likes it. Found the alcoholism interesting - doesn't really understand it." It could just as easily be smoking - I've never had a cigarette since the day.... It's a matter of will power, I think." His drinking is for company. "I go out for a drink just to meet people, and for a change from work - and down at the club." A lot of club members have been to see him. "My social activities hinge round - my main interest is my family - after that my main social activity is the bowls club. That was it - my life just revolved around it." Has made a lot of friends. A club friend is now in the C.C.U. - people have been to see him too. He likes the type of person.

Int: "Are you walking far enough now to be able to go to see him yourself

Him: "I'd love to. But as far as I've been allowed to walk so far is the toilet which is 15-20 yards. As I've told you before, they send you up in stages. You start to walk to the dining room - Well, I've never walked to the dining room yet."

Int: "When you went to watch March of the Day....?"

Him: "...a fellow pushed me in a wheelchair - one of my pals. I wouldn't take a - you feel a little bit frightened when you come in here - I don't know whether it's because it's heart, and heart tends to have a frightening sound about it, - it makes you very careful. I could probably have walked up to the television, but you really have to wait till they give you permission to do a lot of these things, and your body tells you whether you can do it or not. That pain last night has slowed me up a bit this morning - I've been up and I've walked round the bed and I've had a shave."

(Less confident than he had been before)

Int: "Are you saying that it made you feel 'I'm not going to make progress too fast'?"

Him: "Yes. Yes, I'll make haste slowly as they say. Whether it was a little bit of a warning to take your time - I'm taking it as such."

Int: "Could you enjoy the television?"

Him: Enjoy/s television, especially sport. "When I went to the toilet it was O.K., and when I come back, I didn't feel quite so clever. I was glad to get in the bed and lay there, and it gradually went off."

Int: "When you had the pain, did you find yourself wondering what it was?"

Him: "Oh yes. Not only wondering, worrying. Which is probably the same. Anyway it went off and I had a good night's sleep. It's funny...."

(Inadequate understanding of pain)

Interruption for a ward round.

Int: "Doing this amount of walking, how will this work out at home?"

Him: "If I've got to be downstairs, I'll have a bed downstairs - I've got a downstairs toilet. It's a matter of what they tell me. I was under the impression that there was a doctor going to come and see me yesterday, and tell me what I'd got to do when I got home, but I've never seen anybody. If they say I've got to be downstairs, that'll be it. I suppose your physical resistance will tell you what you can do as regards that - you'll know more when you can walk up the corridor. I know Mr. Irwin (another patient) said when he walked up to the dining room where they have their meals he was tired out by the time he got there - he's totally different case to me - he sleeps a lot more than I do. Each person is different. I think if they just enlightened you a little more in here about things - if they told you 'You're getting on O.K. - we're taking you round here for such and such a purpose' - it would make a lot of difference, instead of just 'Mr. Jessop' - when you don't know whether you're going to China, Timbuctoo or where you're going. It's a bit upsetting. As I say, I'll get on all right with these gentlemen, the same as any others. Not only that, there's their visitors that you get on with as well. If there's a night you don't have any visitors, my friend there, his visitors were just as much

mine as his visitors - because I can't stop chattering in, that's probably why. Other people like to be reassured at times about how their people are."

(Many aspects of role-set have less authority attributed to them now)

A visitor arrived - his foreman from a previous job. He had had a heart attack last Christmas. I said I would go.

Mr. Jessop had been quite anxious and depressed during this interview.

8.4.74. Home Visit to Mr. and Mrs. Jessop.

General chat about the garden - he doesn't feel he is caring for it adequately.

Him: "What would you like to know today?"

Int: "I've been wondering how you have been getting on this first week."

Him: "Fine. To be candid, I've surprised myself. I was - cos I was a bit - you know when you came to see me that last Sunday morning when my foreman came - well I was feeling a bit disappointed at that moment because I had just been moved as you know, and I wondered why they had moved me. I thought - Hullo. Because I was under the impression that where I had been you was on your way out."

Int: "And you had just had that pain."

Him: "And there was that pain. And I thought Oh something will happen."

Int: "I thought you were really quite bothered by it."

Him: "Yes, well you see, every little pain you get after you've had a heart attack you begin to wonder what it is - it's just one of them things."

(Pain still not understood)

My daughter-in-law's mother was here yesterday - well, her husband has been a heart patient for five years. He had a pain while he was here and he had to take some little white pills when he gets it. I asked the doctor - very nice - what was the reason I was constantly being moved. He said owing to shortage of staff what they tried to do there was to move the patients who didn't need much nursing into one particular ward, and that was the reason I was moved - 'cos I was only a once-a-day nursing patient. So I bucked up a little

after that.

(Staffs' actions could again be seen as meaningful)

Then on the Monday morning, Dr. A's two second-in-command doctors they come round and asked me one thing and another and examined me - he said 'Oh, I think you'll be O.K., Mr. Jessop, you can go out today if you like.' Of course I was over the moon. Then when the other doctor come round, I said have I got to take any pills or things, he said 'You've got to wait till about 4 o'clock this afternoon till Dr.A comes' - so down your hopes go again. You're up and down in there. One word from them can send your spirits soaring or send them down to your feet. I felt O.K.in myself, though I hadn't walked far. When Dr.A comes, he just looks at me and says 'O.K.' and that was that. The next thing I knew I'd got pills and things, and I rung for my brother-in-law to come and pick us up - my wife was there by then." "Yes" (her)"And we was home. And I walked to the car - you know how long that corridor is - and when I got outside I didn't feel as if I had walked a long way, I didn't feel tired."

Her: "Your legs didn't ache."

Him: "No. Then when I got home, I felt O.K. My brother-in-law stopped a bit and then later on we had other friends come in. It was quite a hectic night in the finish until about half past ten. I've never really looked back since. I walked as far as the newsagents yesterday. That's the first time I've actually dressed and gone down the road. I wouldn't go this morning because the wind was a bit cold earlier on. But I've been round the garden. I take my newspapers to an old age pensioner down the road, so I've been down there this morning. I feel quite O.K., and I sai - of course, I packed up smoking and I've never smoked since the day I went in - the only fault with it is that I feel hungry."

Her: "He eats three good meals a day."

Him: "I eat well, and I sleep better now than I did before." He spoke of the details of his present daily routine "Really in my own mind, I've got on well. To be truthful, I feel better now than before I was ill. But obviously, I wasn't very well before this happened. But now, I don't feel....it feels like a bad dream to me now, it don't seem like I've had a heart attack at all. I can go upstairs, I can...."

(Past reinterpreted to make present seem good)

Int: "It sounds as if you are doing quite a lot."

Him: "More than I expected to do going on what the other patients was doing, 'cos they were all doing more walking about than me in the hospital."

Her: "I have to keep checking him though. I have to keep telling him not to do so-and-so."

(Wife's role)

Him: "I'm an active person."

Her: "I say - I'll do that."

Int: "What sort of things has that been about?"

Her: "Like getting a glass of water, or...."

Him: "Or getting something from the kitchen if she'd forgotten it. We've always been a couple who wouldn't say 'Oh I haven't got a knife or fork.' We've just got up and fetched it - we've never been slaves as you might say, so it's something that I automatically do.... Now she'll say 'Sit down, I'll go and fetch it.' Or I might have left something upstairs, and she'll say 'Now don't you go chasing up there' - 'cause we've been married a lot of years and we've no desire to be separated. So you tend to think along those lines, as I would if the position was reversed. But really, for me, I've made^a remarkable recovery, I think."

(New role-fit because of 'Threat')

Int: to Her "Did you feel happy about him going out for these walks - did you go with him or...."

Her: "No."

Him: "She watched out the front!"

Her: "I kept an eye on him. I let him get his own confidence. He said he could, so I said let him go and get his own confidence - and I'll just keep an eye. I was watching for him when he came back."

('Watcher')

Him: "It was only about a hundred yards. I don't feel tired - I took if very steady mind you, 'cos you're a bit.... - same as the first night they never said nothing to me about not going upstairs - but my friend you met who was there that Sunday morning, who had just recovered and started back, he was in a week longer than me, and when he went out, he had to stay in bed upstairs for a week - now we've got an upstairs and a downstairs toilet so it wouldn't matter, but he hadn't so he had to be upstairs - and he was more or less implying to me that I would be the same, but actually I was out a week sooner than him, and - mind you - I was very careful when I went upstairs, I didn't ^{just} go chasing up.

(Differentiating himself from a 'cardiac wise')

My doctor called in on Wednesday - of course they don't say nothing to you - But in your own mind you know that I'm getting on O.K. - I've progressed in the right direction, 'cos I'm ready for my dinner, my tea, I've just been round the garden having a look - and I don't feel tired. I just feel pleased that I'm out of there, 'cos, for a start I do not like central heating - it kills me." Dislikes it at his son's house.

Int: "Is it tempting to do things in the garden?"

Him: "Oh yes, I want to pull some of the weeds up, I've just been out there now and said it needed weeding. I could have quite easily - I felt I could have done it - whether I could have done it. I felt I want to do something, 'cos I've always been active, I've never been one for lying in bed...."

(Uncertainty about appropriate activity)

Int: "You said you found it boring in hospital."

Him: "It was, laying there. And yet I couldn't settle to a book." Usually reads papers a lot. "But in there, there's this constant fear - is there something else the matter with me? Just when you're feeling nice, they come round and say 'Mr. Jessop!' - and you find yourself whipped down the X-ray or you find yourself having an extra bloodtest, or then you find they've changed the pills, and you think what have they changed them for - Why? It's just my opinion, a little bit more openness on the part of the doctors or nurses about just how you are, could be a tremendous help. But if it's bad news, I'm not so certain about that. But if you're going on the right road, just a couple of words can make a tremendous difference to everybody. I noticed that in there with different people.

(Medical definition of health not clear enough)

Now with Peter (Mr. Irwin) - he was very subject to emotional upset and we had a Pele, he was most difficult to manage - we even had his wife ringing the hospital to ask what was the matter with him, for her to tell him....it rather amazed me....he was a bit overpowering. Fortunately for me I'm a good mixer, 'cos just as I got used to people I was moved and then you've got to make completely new friends. It was a bit distressing to me, 'cos I was very friendly with that fellow next to me, and the wife told me he was having a rough time at the finish - he was very good to me - he wheeled me up to the television and he wasn't really that well himself. But just a little bit of encouragement from the doctors, to say 'Well you're going on all right' makes a tremendous difference to the rest of the day. If you're really bad, you know and you don't need anyone to tell you - but it just boosts your ego." Doctors talk in abbreviations - "and you don't know what they're on about, nobody enlightens you, and you lie there and think I wonder what they're going to find wrong with me now? This is the feeling you have. When they've gone, you compare with your other friends."

Int: "There's something very interesting you said there, that if you're really not well you know - do you mean it's more difficult to know if you are getting better and to believe...."

Him: "That's it. Yes. It's hard to believe - when you're in there it's hard to believe that you're actually getting better.

(Ambiguity re health status)

There was two things what told me - one was I started to feel hungry, and one was I didn't mind company. I sat up with an alcoholic one night trying to talk him into being sensible - so I knew I was getting better but I hadn't walked as far as everyone else, and I didn't know how I was going to feel. I never did go as far as anybody else till I came home. Mr. Irwin - he'd been right down to the dining room. He said to me once 'My legs ache terribly'. My latest information is that he's still in there, but whether he's gone home now I don't know."

Int: "He's gone home now. I saw him on Friday and he was expecting to go out on Saturday."

Him: He asked about other patients - but I didn't know them. He spoke of one who had been sent out on the wrong dosage of pills and he had had to be readmitted as an emergency. He has tried to find out his address. He would like to know how he is. He can contact Mr. Irwin. "One thing I would like to find out, is how we all three go on in comparison with each other - I don't know if you want to do it just to see if you get better quicker than them or.... there was a lot of competition between us. They was ahead of me at one time then I got ahead of them after one was taken bad again, then I got moved and beat them by coming out of the Unit first, then the little chap come out first. I didn't think he looked that well, but the doctors must have thought so. Everybody was saying about when they was going home - this is the main topic when you're getting better...."

(Use of 'cardiac wise' as a reference group)

Her: "It's a nice place when you're...."

Him: "The treatment was nice, as far as I was concerned - the treatment and the people. - who ever they were. The nurses, I couldn't speak too highly of them, whether they were short-handed or that - and we all tried to help them as much as we could....they did their job, and I felt they were very kind....They're nice places, hospitals, to go in when you're bad, but once you start to get better, home's what....Of course, they ask you what type of home you've got, and what type of wife you've got..."

Int: "We'd better not ask you what you said!" Mrs. J. laughed.

Him: "Well, everybody's home life isn't everybody else's is it. We were only saying this morning, there was only one fellow I met there who hadn't really got a family - apart from some old men. But everybody else had got marvellous wives from what I could hear....you hear a lot sitting round when they come and visit. Everybody I met had got a good family....whether they all put their best behaviour on when they're in hospital, I don't know."

Int: "I've been finding that, and I've wondered too!"

Him: "Of course you only read about the people with family trouble, you don't read about the families that are happy and comfortable do you - they don't make the news." A friend has been to see him - he used to know his wife 30 years ago and they remembered how he had helped them then - so they came to see him. "The difference between a hernia and a heart attack - the one, everybody thinks you're dying when they say 'Oh George has had a heart attack' and I've had people come or ring up and I had a cheque for £5 from (previous workplace) yesterday - not that I'm hard up, but somebody had heard I'd had a heart attack."

(Responses from 'others')

This is the sort of thing that has happened. I realise I haven't wasted my life - and I'm not a religious person - but the amount of people that somewhere along the line I've helped or....and then when this has cropped up....you find out who your friends are then. It

really amazed me that I've made so many. My trade is a bit - like a grapevine....we've got a lot of friends that way - their's was genuine concern for you to get better - not sheer curiosity. So I was pleasantly surprised." Chatted about friends. "Of course, I've got to pack my trade up. He told me that the morning I come away. He asked me what I done for a living, when I said I was a panel beater, he said 'I'm afraid that's out. You won't be able to do that any more'. I said "Well, I'd made up me mind to that the day I come in'. But what I shall do now, I haven't given any particular thought to, as it's not something I shall bother about till the time comes. There's only me and the wife, and we ain't exactly destitute, so I shall probably take a job with a lot less money than I'm used to - just enough for us to carry on. Because this is what happens - I'm 62, and you save up a certain amount of money for your retirement at 65 - so if you retire three years early, you're using your money up three years before you expect to use it. So depending on how my health is, I'll do something. We don't need a lot of money... I shall wait and see."

(Medical confirmation of 'High Threat' necessitating a 'High Loss' change)

Int: "What^{are} your views about that Mrs. Jessop? Are you glad that that is definite, or....?"

Her: "Well - he can't carry on, its much too hard really - so you've got to look at other fields. So long as you get enough to carry on and pay your expenses."

Him: "What in effect we shall be doing - instead of saving a bit more money for our retirement, we shall just be living on what we earn, and keep our capital for when we do retire. This is all I want to do I've been a book-maker's clerk for 14 or 15 years - so I have one string to my bow. I've always been very good at figures - I should have been a mathematician. My son is a mathematician. Unfortunately I passed for the grammar school when I was a kid, but my parents hadn't got enough money to let me go. My son was more fortunate."

Apart from the finance, my parents weren't that educated to know what education was, in them days. My father was a fishing skipper, he never went to school after he was 10 years of age. So they didn't realise what you was missing. I always said my son would never miss anything - I'd go all the way with him." Son got a degree - he has the ability. Has a good job "We reflect in his limelight."

Int: "Is what you're saying, that you're not going to be in any hurry...."

Him: "No. I'm going to stay on the sick as long as they'll have me. This is one thing I'm determined to do." Could go to a Working Man's club home for a fortnight. "As regards work, I'm in no hurry at all. If he said to me 'Start work at Christmas', I'd say 'O.K., I'm in no hurry.' Because the money we shall get off there (National Insurance), for our simple wants, especially now I've packed up ~~smoking~~ and I've more or less got to pack up drinking. The only expenses will be our food. I don't say I shall pack up drinking - the odd half pint, I don't think that will exactly see me into an early grave - I don't mean to drink so you can wash your feet in it.

(Reducing 'Threat' because of high 'Value')

Before this happened, I was drinking draught Guinness, because I thought the doctor thought I was anaemic, and I thought it was doing me good - but if I'd known it was doing me harm.... Nevertheless it may have bucked me up, I don't know. They say they give racehorses a bottle of Guinness a day - so if it's good for them, it should be good for me...."

Int: ~~Wondering~~ how he expects to sort out his tendency to be active with not doing too much.

Him: "One thing I'm going to do. I'll still keep my interest in the administration side of bowling. I shall still be captain of the team and I'll go with them wherever they go even though I shan't play. They'll come round here and take me to the different meetings, wherever I want to go....so probably, where I was engaged in playing in these competitions, I shall do rather more just watching or....you

can have a lot of conversation with people that can pass the time away. Once the summer time comes, not being active will be a problem for me, as I've never been one for laying in bed. The day before we was taken bad, we were finishing re-tiling the kitchen - we said, we'll paint and paper next week, and before you know where you are, you've got a heart attack. We've just got to put them things on one side. I shan't try to do anything silly. What I want to try and do, is what I did in hospital - whatever the doctor tells me to do, I done. He told me to pack up smoking, I done it. He told me to diet, I done it. Whatever he told me to do, I've done. If he'd have told me to jump off the cliff, I'd have done it! This is the faith you have in these people - This is what I intend to do.

(Being sensible equated with following medical directions)

I was a bit concerned about the tablets they gave me - they gave me a hundred of one. They gave me a book I have to carry when I'm taking these tablets - Warfarin. In there, I was having one a day - and they gave me this book....I'd got to take four the first night, three the second, two the third, one the next and then stop. Still being concerned about what happened to the other man, I told them about this as I couldn't understand why they had given me a hundred. I told them about the other fellow - he had a look and said 'I just want you to take one of these - don't worry about that, as all your tablets are very minute doses'. I'm not a pill merchant.

(Worry because of apparent medical inconsistency)

I prefer my medicine in a bottle of Guinness to a bottle of pills - I always think that's my cure for everything - I've got a lot of faith in it. When I was in hospital before, they told me to have that. I shall find out off the doctor before I have a drink - I shall ask him, because while I'm on tablets I might not be allowed to But my drinking consists of one half pint and a chat, because I like company."

Int: "How often are you going to see the doctors?"

Him: "Well I've got to see my doctor this Wednesday. I've got to see the specialist the 1st May....my own doctor, after Wednesday, I don't suppose I shall have to see him no more till after May. I expect him to give me a note to take me to the end of May...."

Her: "You may have to see him once a week...."

Him: "....I doubt it. I've got enough tablets. We only live four doors from him, so in an emergency - we shouldn't do what we'd done before. Think we'd got indigestion. It's a good thing it happened - I consider now it's a good thing it happened, as it could have gone on more and I could have had a really bad one.

(Learned new Health behaviour)

I don't consider I had a bad one. I don't know. You can't really - I tried to ask other people what sort of pain they had - but pain is a difficult sort of thing to describe ain't it.

(Attempt to classify severity)

Mr. W. was one that could take a lot of pain. I heard the doctor say to him his trouble was he only shouted out when he was nearly dead - that created problems for the doctor - 'cos he should have gone back to the doctor before after he found these pills was.... but he never took any notice - he's one of these fellows that can carry pain."

Int: "You're feeling that yours wasn't serious?"

Him: "This is the feeling I have - I may be wrong. I shall ask my doctor whether mine was what they term a bad heart attack or a slight heart attack - because....I don't know if there's any difference. Some people absolutely collapse with them don't they. There's the difference between a stroke and a heart attack - a stroke is up top and a heart attack is here (tapping his chest) I shall ask him whether that was a bad one or not. I had a pain at the time, but I never thought it was a heart attack - I got a couple of Rennie's and went to bed - didn't sleep, mind. I walked down to the doctors the

next morning."

(Trying to clarify his medical understanding)

Int: "I don't really understand how you got to the doctor's the next morning."

Him: "Just stress will power I think....I had a wash and shave before I went, and I'd got a heart attack - This is something they asked me in there, though they didn't comment, how it happened and how it started. But the worst I felt was the hour I sat in the surgery - how I sat in there I shall never know - I couldn't do it again. Just sitting there and take the pain for an hour."

Int: "Did they not realise how ill you were feeling?"

Him: "They didn't realise down there till I walked into the doctors surgery, till I got into him. He took one look at me - and panic stations. It must have shown in my face. There was these three ladies there - they all had to go back in to see the doctor three times - I thought 'Good God, not again' - this was the feeling I had - I thought I shall have to go out in a minute or do something - but eventually I got in to him, and he took one look at me and that was that. He sent me back home, and a specialist, and away - it was as quick as that. Yet I'd been like that for 24 hours...."

Her: "The time you was laying in bed, you didn't seem so bad, it was when you got up and moved about...."

Him: "I didn't make an appointment till 11. This is what I can't quite understand about it - you see, I had a pallor of a heart attack when he was 46 - he lived just round the corner. He was down at the club that night, and had a couple of drinks, and when he came home and he was like me, he had indigestion. When his missus come downstairs to get some - you know them powders they take for indigestion when she got back upstairs he was dead. Whether I was close to that if anything had...."

('Cardiac wise' can cause anxiety)

(Part of interview missing while tape changed)

Him: "....not smoking, that's a big thing. People who haven't smoked don't realise, same as sugar. I haven't had a piece of sugar since I was in hospital. I was a ~~three-spoonfulls-in-every-cup-of-tea-man~~. He said I'm not to do these things. They got nine pound off me in there". Some of his food had been like a diabetic diet. "If I keep my weight down, it'll be better for me."

Her: "The less weight you've got to carry around the better for you. I'm supposed to be a lot less than what I am."

Int: "I was wondering how it was affecting you."

Him: "Doing her good!"

Discussion of her difficulties over dieting. She put on weight after being pregnant and didn't lose it - there was less medical care then.

Him: "If anybody means to me about the National Health, I could crown them, I could. The money I ^{paid} out for her in those days, and now I can go to a place like the.....Hospital and have first class treatment without worrying about paying the bills or anything - even the tramp of the street can go in there and have first class treatment - anybody. I don't mind paying taxes, I don't mind paying rates because, to me, that's there." His father had saved up to buy a fishing boat but had to spend the money on medical care when his wife was ill - "I've never forgot it. If I hadn't had a bit of money when my boy was born, my missus wouldn't have been here today.... that's why I don't begrudge one penny I pay in taxes or rates.... because to me, money can't buy these things. All the money in the world couldn't have bought the treatment what I've had there this last fortnight - specialists and specialist treatment, it would have cost hundreds of pounds if you'd got to pay. I'm a big advocate for National Health and socialism - that's another story. This to me is the finest thing there is."

Her: "We're the only country what's got it."

Him: "On the same scale, yes. When you've seen the same things as I've seen over the years, - our Dad dying because they couldn't afford the proper treatment, and that sort of thing. This to me is a marvellous thing, that I could go down to that doctors that morning and within twenty minutes, I could have a top specialist in the Midlands in my house for nothing. This to me is a big thing - it's marvellous. I can't praise it too highly. There's another thing I'd like to comment on, ... - how unfair it is on nurses to have to pay to take their exams and to be registered." Talked of being patient for the exam, which he had enjoyed. "The nurses are really dedicated." Talked about the alcoholic patient; had been interested in him, and hopes to hear news of him. "You can get involved with people - I'm like that."

Int: "Is it quiet here compared with the hospital?"

Him: "Up to now we've had rather a lot of people." Talked of people who have been to see him - visitors every night. Used to be very quiet and never saw people at home. Showed photos of his family - miss them very much. Have thought of moving nearer them. Son is trying to move south nearer them - he has done very well in his job.

Int: "I'm very intrigued to see you're still wearing your hospital bracelet (for identification)"

Him: "Yes. Superstitious! I think while I've got this on, they won't call me back." I'll keep it until I feel well. I've got a feeling if I take it off, I'll be back! It's pure superstition. I've only been out a week, and I'm keeping my fingers crossed - it's one of them things, you just don't know. It's not like going in and having an operation and they cure you before you come out - you don't really know whether you're cured or whether you ain't.

(Ambiguous health status and fear of recurrence)

This is the whole question. They tell you - well, what he told me when I came out, he said he didn't want me to consider myself an invalid. He said 'Now don't consider yourself an invalid when you

get out, Mr. Jessop, what I want you to do - the first day you're out, I want you to walk to the end of the block, then the second day, I want you to walk a bit further, and so on until you can take a walk naturally.' Well, I haven't quite done it as religiously as that but I've walked down the garden and I've gone down the entry and I went to the newsagent, and I've felt quite O.K. Sitting here talking to you, if I don't tell myself I've had a heart attack, I wouldn't know. This is how I feel. But then, I felt like that in hospital once they'd cured the pain, and the fact that they keep making you about. But apart from that, I didn't feel ill in hospital after I came out of the Unit, apart from when I had the pain, of course that was - I don't know if it was eating a banana late at night or....just something I don't know - but that was the only time I was really tired. Yet, Mr. Irwin had a pain several times - because he was on a lot more tablets for one thing. My tablets is the same now as they was when I went in. What they can establish from your blood - it's marvellous what they can do with it - because it must tell them what pills you need to thin it down and all this. They do this every day - twice a day sometimes I had it."

Int: "I can understand that you find it difficult to know...."

Hin: "....how well you are. You see, I don't know. It's all very well for them to say 'You're not an invalid, Mr. Jessop' and then in the same breath they tell you 'Well you can't be a panel beater any more.' Well this tells me that you ain't the bloke you was before it happened - obviously. To what degree you're not an invalid it's difficult to define. But it's a fact that you can't do the work that you did before - something I've done for 45 years - so that makes it to me that you just ain't the bloke you was. What the in-laws father said to me yesterday - 'You've got to slow down, that's the top and bottom of it - When you see your bus going off from the bottom of the street and you're used to running for it, you've got to wait for the next one - it's as simple as that'. I don't know just how simple

that's going to be. The fact that I won't be able to play bowls - well bowls to me was a relaxation not hard work. That's another thing that makes you into a semi-invalid - from my angle, not from the doctor's - but from my angle, if I can't do the things that I done before, I'm a semi-invalid, ain't I. That's how I would interpret it."

(Contradictory medical statements causing uncertain self-definition)

Int: "Has anybody said that you can't play bowls, or...."

Him: "No. There's a lot of effort in the game that I play." He explained the differences between his game and what I had probably seen people play - "it needs some pushing. If the doctor would tell me these things - I don't know whether I shall have to find out these things through playing or through the doctor telling me. If he told me I could play, all well and good. But if he tells me, no...."

(Still dependent on medical prescription)

Her: "It would be hard for him to know what you meant by play and what you meant by it being hard work. You only play once a week, but he isn't going to know you're only going to play once a week - he might think you're going to play every night of the week."

Him: "I used to do, in the summer...."

Her: "You've got to use your own...."

Him: "....discretion. A lot of it you've got to find out for yourself, I should imagine. Your system itself, will tell you what you can do."

Her: "After this year - Give it a rest one year."

Him: "I shall give it a rest in any case for this season, and see what happens."

Her: "But perhaps after this year, you may be able to play a game a week."

(Own decisions veer towards caution)

Him: "But if I go on making the same progress as I've made now - you see, actually I feel better than I did - I'm sleeping better than I did before - I never lay in bed till a quarter to ten in the morning - that was the middle of the day to me. Even Sunday, I used to be up

at a quarter to six the same as every other day of the week....Now this is a bit foreign to me - this morning I didn't wake up until nearly nine - whether it's because I've gone to bed with nothing on my mind or anything of the sort, and you're fully relaxed I don't know....er it could be the tablets, it could be a lot of things. I wouldn't have sleeping tablets in hospital - I kept off them because I don't like them because I think they're habit-forming. I thought, well I can't expect to sleep in here, not laying in bed 24 hours...."

Her: "I don't think anyone sleeps well in hospital."

Him: "There's too much noise - especially in ~~that~~^{that} Care Unit - because the telephone was going every five minutes. Then when you did get to sleep, they woke you up to give you an injection - nevertheless, the first night I was in there, when they stopped the pain, I dosed off and I slept. I used to sweat tremendously - and so did Peter (Mr. Irwin) - I'd always got different pyjama tops to bottoms, because I used to sweat and take one off and put a dry one on. As I got stronger, I didn't sweat so much - whether it's the weakness or not - I suppose a certain amount of fright - I think everyone is afraid to a certain extent when they're in hospital - unless they're that ill that they don't know or don't realise - I think you all put on a brave front when you're in there, but I think you're all wondering what the devil they're going to do to you. It's the unknown that you're afraid of."

Int: "This is a different sort of unknown for you now that you're back and going to try out...."

Him: "That's right."

Int: Arranged to visit again in about a month - to see how things are then

Him: "My life's certainly going to be different, but to what extent, we shan't know till it's happened."

Collected diary from him.

7.6.74. Home Visit to Mr. and Mrs. Jessop.

Mrs. Jessop had mistaken the time we had arranged, and was out shopping, returning towards the end of the interview.

Him: He said he was well.

Int: "You reckon you are well?"

Him: "Well, I'm all right in a lot of ways, but, mind you, I think I had this before it started - angina as they call it. Which means, when I'm walking up from the Club lunch-time, I have to stop about three times coming up the hill. This is something I've got to live with. They've given me some little tablets to take when I think that I need them. I use them when I think that I need them, but at the present time, if I stop for a moment or two, it goes off and I'm all right. I think the natural remedy is better than pills - it's only what I think. Otherwise, I'm quite all right really."

(Tentative admission to uncertainty re health)

Have been to stay with son for two weeks - had a worrying time because daughter-in-law was ill. Wonders whether to go to Working Men's Club convalescent home. "Unfortunately I've got to see the specialist on the 26th, or I think I'd have a fortnight at the convalescent home - it would just cut into it". It would need to be arranged. May go back to stay with son again, or go to his sister's at the sea. He thinks the younger generation are too soft - abuse things like social security. His generation had to cope with a rough time, and didn't expect so much - he was contented with what he had, even though it wasn't much. Had to save up for anything - even to go to the pictures. Son has more than he will ever have. Is happy with what he has got. Enjoys simple things like wild flowers growing in Newcastle.

Int: Has illness changed these ideas, or has he always thought like this.

Him: Has always liked things like that. Journey to Newcastle by coach had gone all right. "The only thing that bothered me was the wife trying to carry the suitcase. That was the thing that bothered me more than

anything. I don't feel physically....I feel I could pick up the biggest suitcase there is and walk to the door with it.

(Discrepancy between activity he thinks possible and what wife will allow)

As the doctor was telling me Wednesday - they've got a different idea these days about wrapping people up in cotton wool - of course, certain heart attacks, obviously - it depends on how and what and where. They've offered me a light job at work - less money of course but that's not something as bothers me. He said to me 'We've got a new conception about this today, that normally with heart cases we wrap them up in cotton wool and they weren't allowed to do this and they weren't allowed to do that. Now, we've got a different idea all together. I don't mean you can swing a sledge hammer or anything like that' But I got up the steps and cut the bottom hedge, sort of thing. You can do that sort of thing, where they wouldn't have let you do it, even five years ago. This is how he explained it to me."

(Medical explanation helpful)

"I was rather surprised this time, because he was a bit abrupt last time I went to see him. He said 'If you haven't got a job by the time you come to see me again, you can go on the dole.' Which I didn't take very kindly to - seeing I've only been on the dole once in my life, and I was 59 when that happened. Anyway, I didn't say anything. Well, this time he didn't say anything, he just said 'Oh well, you see the specialist on the 26th, I should mention to him that you've been offered a lighter job, and ask him if he thinks it's O.K. to start'. This was a different approach altogether. Whether he'd had a letter from the specialist since my last visit, 'cos I'd been once since. I've been once since you was here. He was very pleased with me really. He said I'd got no blood pressure."

(View of G.P./hospital relationship)

"Apart from coming up the hill sometime, I don't really feel any different to when I was....Actually I used to have this sort of thing - not so badly as I have it now, mind you, before. If I'd

been a bit more lazier, I wouldn't have gone to work, I'd have had a good rest and it wouldn't have happened - but that's past history."

(Reinterpretation of past)

Int: "But they are still saying not panel beating, are they?"

Him: "Oh no, I can't do the panel beating I've finished with that. But I've got a little job on a small foot press - it's all automatic. It's an insult to my intelligence really. I wanted to go on inspection and unfortunately the chief inspector has got a bee in his bonnet about younger men - that's ridiculous really because the younger men haven't got the experience. Everybody wanted me to go on inspection, bar the chief inspector - this is it....I was recognised as a good tradesman, so I was actually the ideal type for inspection. There's not a lot of difference between the money for inspection and the money for the job I'm going on - it won't make any difference. But anyway I didn't get that. I was talking to the second hand in the press shop when I went down Wednesday, and he said 'The job's open for you when you like to start' I said 'I'll try it anyway. It'll probably be monotonous for me - I've never been used to doing work of a mass produced type. I'll give it a try and see what happens'. It's £20 a week less than....but it's enough for me and the wife to live on which is all I'm worrying about. It's all I'm interested in. I'm 62 in a week's time, and all I'm interested in is being able to keep at work until I'm 65 and I get my pension - so the money that I've saved for my retirement won't be spent before I retire. Actually, a friend of mine had a heart attack before I did and he was telling me the same thing as I'm telling you. This was his biggest problem.

('Cardiac wise' confirms his ^{own} attitudes)

All I want is about £40 a week, which is quite a satisfactory wage - but plenty for us. I don't own a motor car - and I don't smoke now!"

Int: "You've stuck to that?"

Him: "I've stuck to that. I have a drink - limited. I have a pint and a half of Guinness every day. I don't go out at night, unless there's a blinding match on and then me and the missus go up there. I have me pint and a half of Guinness. I asked the doctor - 'I'm not going to give everything up' I said 'because, if I give up smoking and drinking, there's only work left - I'm not just going to do that'. He said 'A glass of beer won't hurt you, it won't do as much harm as them cigarettes'."

(Reinstatement of 'High Value' activity - bargaining with doctor)

Int: "I had the impression when I phoned (to make the appointment) that he expected the doctor to start him back at work.

Him: "Yes. I was fully prepared to go to work. It was rather funny - it took the wind out of my sails, because the month previous, he said to me 'If you haven't got a job within....' 'Cos I'd had a letter from the National Health people, saying that they wanted to interview you to see if you're swinging the lead or this sort of thing. So I took it to the doctor. He put on my certificate that 'this gentleman was a panel beater' which told them that my work was hard. I was expecting to be signed off, and he never mentioned it. All he said was the same thing when he signed the ticket as he did before - so whether he'd had some information from the hospital or not, I don't know. He didn't ask me much. They don't examine you. They always wait for you to say how you are. I said 'I'm all right. It's only that I have a job to get up the hills' I was quite content." Has been for quite a long walk - across town "I felt a treat"- on way back stopped for a snack, then had a job to walk up the next hill. "If I don't eat nor drink I can walk on, even up hill, but once I have something to eat or drink - it's something that has only registered suddenly with me - I can't do it."

(Change of tape)

Him: Was cross with daughter-in-law for not taking care of herself. She wasn't doing what the doctor said - "I wanted her to do what the

doctor said - I said to her 'Well, I've packed it up (smoking)'. She said 'I wondered when I was going to hear that.' She is better now and has cut down her smoking. She is lonely. Son hopes to transfer to Nottingham within same company. He chatted on about son.

Int: Sounds as though he is feeling confident about doing more.

Him: "I've got all the confidence in the world now." Went for walks in Newcastle which involved steep hills - "and it never bothered me at all. When I get this pain, I just have to stop. There's no arguing, I've just got to stop. If I was in the middle of the road, I'd have to stop, but apart from that, there's nothing I don't really feel I couldn't do." Goes for long walks - and sometimes takes a bus back if he's had something to eat as that is when he feels the pain - "they tell me - the specialist tells me + I've got to live with this angina - he said 'It might get a bit better as you get fitter'. Well, at the moment, I'm as fit as I shall ever be - this is how I look at it, so I've come to the conclusion it's not going to get any better. 'Cos I feel well, eat well, sleep well, drink well and that - and I go out with the bowling team on a Sunday morning, I don't play, but I go out with them.

(Present health defined as new normal)

No, I shan't play this summer. I go with them - for the company. When you pack up smoking, you've got to find something to do - to keep you occupied. This keeps you occupied, and you forget these other....it's there somewhere in the background. I dreamt about smoking the other night, and I was ever so pleased when I woke up and found I hadn't started smoking. I've smoked all my life. I packed up smoking when I went into hospital sixteen years ago - and I smoked again when I came out. That took a bit of doing - to have an operation, and say I'm not going to smoke. I wish my daughter-in-law had had got the same will-power."

Int: In last interview, he said it was difficult ^{to know} how well he was - how has he been working this out?

Him: "I think it's a gradual process really - you find yourself doing a bit more. You try to do a bit more....you find I still have to stop two or three times."

Int: "Was it then doing things and finding it was all right?"

Him: "Yes, that was the way it came about." Other people did things for him at first - then he tried them.

(Confidence growing from achievement)

"I've been a strong person all my life, so it hit me pretty hard not being able to - seeing the missus trying to cart the suitcase and get it onto the taxi - when I should have got hold of it - I could do it now."

Int: "Do you think she would let you do it now?"

Him: "Yes, she would now, because she knows that I've got sense enough to know whether I'm doing too much. This is the....you see, I've never done anything the doctor's told me not to do - I haven't done. I've been under their instructions from start to finish. This walking, they told me to do that, and I've never lifted anything till I felt I could lift something.

(Confidence from keeping medical instructions)

The missus spoilt me when I first come out - whereas before it was the other way round. She'd say 'I wonder where my glasses are' and before I knew anything, I was upstairs looking for them. But it's something which you acquire - this is the biggest thing to acquire is the fact that you're getting in your own mind that you're not seriously ill - this is the biggest thing of all. You see, if you lie awake thinking that you might drop dead walking up the street - it's no policy.

(Confidence is not so easy)

I'm a real fatalist that I think I've had a damned good life, and if it happens, it happens - now this is me. Where some persons, they go into an oyster and think I daren't do this, I mustn't do that.

(Some 'cardiac wise' a negative model)

I think - well 62, I can't grumble - some people die at 25. But I haven't done anything to make it come nearer. If I thought that anything I was doing was going to make me die sooner, well I wouldn't do it. - Like the smoking. That gives you confidence for other things. I know now that when I go up to the doctors and he sounds my chest, whatever it is, it's not smoking that's caused it in the last three months.

(Possibility of recurrence recognised with action to avoid it)

I was fully prepared to start work on Monday, I was. Not my old trade - just a little job....the only thing is the monotony."

Int: In previous interviews, he had talked about taking several months off how have his ideas changed?

Him: "I would stop on this (sickness benefit) as long as the doctor would let me. I wouldn't go on the dole. I think I would rather go to work than go on the dole - this is....because I don't feel bad enough to be on the dole - if you know what I mean. I was quite prepared to start work on Monday and give it a try, but by a certain rule, I was just as pleased that he put me on for another month because now it will give me, even if I start work the next time, it'll only be for a week and then I've got fortnights holiday, so I'm only going to do one week's work in the next two months. So that'll be five months I've been off - this is what can happen - you can get so that you don't want to go. It's nice to get up in the morning and the missus fry you a breakfast and make you a cup of tea and you go and get the paper and this and that, and then about half past twelve I go down the club and have a pint and a natter with the lads, you come home - you're living in a little world of your own.

(Convalescence becoming institutionalised)

Fortunately, we ain't hard up - like if we want to go for a holiday we can go for a holiday or do anything you like - so we're in quite a good position as you might say to enjoy....But the dole is a different matter to me. The dole is something that I deplore. I've

only been on it once in my life, and I deplore the dole. I think if you've got to go on the dole, you're well enough to work. The only thing was whether they could find me a light job - there ain't many light jobs there. This new section has only been going about six months - it's good idea...."

Int: "If the doctor had said it was O.K. to be off longer...."

Him: "...on the sick, I shall stay - Until he tells me that I'm fit to go to work. 'Cos the specialist should know more than me - if he tells me I'm not fit for work. If I want back to work too quick - and this has happened to a lot of people - they went back to work too quickly, either through avariciousness or what have you -

('Cardiac wise' a source of anxiety)

your sick money don't keep you, though if you hadn't got any money, it would have to keep you. We're quite comfortable, we're not extravagant....the telephone is about our biggest extravagance and only because the lad's in Newcastle; apart from that, we live well, but we don't need that much, and me not smoking has made £6 or 7 a week difference - it cost me somewhere in that region. So we jog along fairly well, both financially and we had a holiday in Newcastle - we pay our way there but it's not like going to a hotel. I was quite prepared to start work - I wasn't that keen - when the sun was shining, I thought this will do me the world of good - having a bit of sunshine, In fact they all at work think that I look better now than I did when I was at work - this is the general impression. Whenever he tells me to go, I'll go, but I won't go on the dole - if my firm had got no job, I'd have had to go on the dole until I got a light job, but that wouldn't appeal to me. If he tells me I'm fit for a light job, I'd go."

Int: What does he expect specialist to say?

Him: "I think he'll say I'm pretty fit, because I haven't got any more wrong with me now than I had when I last seen him - I still have to stop, which I told him about, and that's the only thing I can tell him. I get this odd pain now and again, but it isn't a heart attack

pain - I don't know if it's because your blood can't get through your arteries or whatever it is - it's some reason for it. They don't enlarge too much on....I think they should really. I think they should tell you just what angina is - I don't know what angina is - they put it on my ticket, but as far as I know it's like hardening of the arteries as they call it, but that's as much as they tell you."

(Inadequate medical explanation of pain)

Int: What did the doctor say about tablets?

Him: "I'm having the same tablets now as I had in the hospital - and the ones that he give me to put under my tongue, I've never taken yet. I've got them, and I've always got them with me, so if I was taken bad quick, I've always got them. But the ones I was afraid of, I'm still taking them, but I'll probably finish them in about ten days - they were the Warfarin - the stuff they use for poisoning rats - it thins the rats' blood down. That's what thinned that other poor chaps' blood down - they give him the wrong dose when he went home - the blood was coming through his skin like water - that's how they kill the rats. The doctor said 'Take them what they give you in hospital and when you've finished them, knock them off'. Apart from them, I'm still taking two types - they don't seem to do anything really as far as I know. I'm a little bit lachrymical. I always keep some with me - so if I stop out, I can take it then. But I don't feel any different before I've taken them to what I do after - whether I'd feel any different if I didn't take any for a day I don't know. But I take them at all sorts of times....but I don't really know what they do. I think if they told you a little bit more - mind you, a lot of people can't face these things - if they told you 'You've got about two years to go - make the most of it'. But some people can't face that sort of thing, can they?. Like with these tablets, if they told you what they do, I'd have an idea. They don't seem to do anything to me - they must do something, but....I'm taking

them with Guinness and all sorts. Now my daughter-in-law's father, now he's a different cup of tea all together to me - he has to take these little ones and he takes no end of them - I speak to him in the surgery at work - now if he has a beer with his tablets he'd be like a drunken man, but with me it don't make no difference. If it made any difference, I'd stop one or the other, but I don't feel no different. I don't know what they do, but they must do something, as they're the same ones as they give me when I was in hospital - so they must do something." He produced bottles of tablets. G.P. has also given him iron tablets for anaemia. He eats more because of not smoking. "I feel well - the only time I don't feel well is when I have to stop - it's one of them pains what stops you. I think, I wonder what would happen if I didn't stop - it's that sort of pain. What he said to me is: 'You should take one of these little ones (pill) before you go for a walk' - but it doesn't happen when I go for a walk - it happens when I've stopped and eaten and drunk something. It's a good walk from here to the Income Tax place, and I go the long way round. If I can do that, like.....in myself, mentally and physically, I feel very well. I was more worried about the daughter-in-law than I was about myself, when we was up there."

(Uncertainty about medication and health status interact)

He talked about her illness and her home-sickness. He finds it easy to make friends.

Int: "That helped you to cope with all those changes at the hospital."

Him: "Yes. That's the way I am - if I'd been an ordinary person who didn't want to mix...."

His wife arrived back from shopping - some general chat.

General talk about their holiday and their plans for another one.

Int: "Do you feel he's pretty well, Mrs. Jessop?"

Her: "Yes. He's all right."

Him: "I was telling her about how I have to stop...."

Her: "It's when he's getting tired, he has to stop, I've noticed. At the

beginning of the day he's all right, but when he's getting a bit tired, or when he's had a meal - it's the extra weight, isn't it. I can't go out and do anything if I've had a big meal - never could could I?"

Him: "No, but this is a different pain to that - because it's not an indigestion pain at all...."

Her: "But you've got the extra weight on you, you see."

Him: "I don't know what it is. I'm going to experiment....because this has happened to me so many times - that I can go out of here and I can walk no end of a distance, but as soon as I stop and have something to eat and drink, then I have to start stopping coming back. So, if I go for a walk and don't stop on the way home, that'll tell me whether the one has got any connection with the other...." He repeated previous accounts "I was quite prepared to go to work on Monday, wasn't I?"

Her: "Yes, but I thought to myself, well - I don't really think you're ready for work till after the holiday. It wouldn't be so bad if it was the middle of winter, but come this lovely weather - I think it does you more good to be at home than there."

Him: He'd got plenty to do - might go to the convalescent home or back to Newcastle. The hospital appointment will cut into the time. Talked more about their last stay in Newcastle.

Int: Asked if he had kept in touch with other hospital patients.

Him: Has written to some and visited some others - they are going on O.K. Explained how he had got their addresses. He talked more about the man who had been so ill with the tablets, but never complained. He repeated the conflicting instructions he had been given about these same tablets.

She offered tea - but I said I must go.

I asked if I could come again - perhaps by then he would be back at work.

Him: "Oh, yes - I should think so. It's all very well to talk about work, but there's a lot of difference between being able to come home and sit down when you like, and do what you like - that'll tell me how well I am. Once I go there and start to do that - that'll tell me more than anything else, because now I can just sit down, or if I'm cutting the hedge and want to stop, I stop - but when you're in work, it's a different cup of tea all together. That will tell me...."

(Work will be ultimate definer of health status)

Her: "Still, you're not going on a hard job - he can stop when he wants to stop."

Him: "I ain't pushed, like....still I suppose every job has got it(s.... I liked my own job - my trade. I told the doctor - It's like you suddenly being struck off the register - and you finding yourself being the doorman at the hospital instead of the surgeon'. It's a similar thing. That is the difference."

(Social status threatened)

Her: "Still you're 62, not 18."

Him: "You're 62 tomorrow! I'm not 62 till next week - so you're older than me!"

Her: "So I can wear the trousers then?"

14.8.74. Home Visit to Mr. and Mrs. Jessop.

He talked about how his garden was looking.

She said a neighbour was leaving and the new person coming had had polio - she was surprised I didn't know her. The change will make a difference to them. More informal and personal chat.

(Their identification with 'cardiac culture' assumed to apply to interviewer's reference group)

Int: "Did you decide to go back up to Newcastle?"

Him: Have been once or twice and also to Lowestoft. "I'm as well as I'll ever be now - that's the conclusion I've come to. I'm supposed to be starting work Monday week."

(Present health is now normal)

Int: He had expected it to be sooner than that.

Him: "He wouldn't let me go - the specialist. What happened was....I've been to the hospital four times, and I've been a different one every time. Now you've got to explain to them - they've got your case there, but you've still got to explain to them. Now the last time I went, I saw the Indian doctor who used to come in the ward....he put me on some new drugs - well this time I went to see the specialist he had to look them up to see what they were - he conferred with another specialist there - I suppose they're all people being trained under the top specialist....and he talked it over with her and took me off them. Then I told him 'My doctor wants to know whether you think I'm fit for work' so he said 'Well, what do you do?' I said 'I'm a panel beater'. He said 'That's out' I said 'Yes, I know that's out - but the firms offered me....' The firm expected me back after the holidays, and they rang me up to see why I hadn't turned up - so I told him 'I'm still on the sick'. So he said 'Of course, you can suit your own hours, you can come in when you like and go out when you like'..You could go in at nine and leave off at three for the first week or so - or go in for two days and have a day off - this is how he implied it to me. So I said 'That's very good of you - next time I see the doctor I'll tell him'. So when I see this doctor this time, he asked me all the particulars and gave me a damned good sounding and he said 'Give it a try and see what happens' So when I see my doctor next Friday week I've got to tell him what they says, as he's more or less guided by them at the hospital. So we shall see...That'll be just five months - just over."

(He facilitates communication between G.P. - hospital - employer)

Int: What will his job be?

Him: "I'm going out of my trade - but it's all allied. It'll be a small foot press."

Int: "This is the one you told me about before - I wondered if they might have suggested anything else."

Him: "At the moment, that's all they could....I'd have like to go on inspection or the stores - because we only want enough money to tick over till we retire. What I actually want is to get just enough money to tick over and do as least work as possible for it! That's how I am, and that's how this has made you feel - I'm going to know my limitations - sometimes I can walk a long way, sometimes I've got to stop three times coming up the hill. He's told me that's something I'll never get over, that's something I've got to live with. We lead a pretty sedate kind of life - we don't go out much. I still go out with the bowling team, but I don't play - we may go out on a Saturday night to the club if they come and pick us up, otherwise we don't do much."

Int: "Is that less than you were going out before - say, last summer?"

Him: "Oh definitely, yes. I was a lot more active last summer than what I am now. It's left its mark - let's put it that way. I'm not the man I was before I had it - this is how I see it."

(New normal has involved unwelcome change)

Int: "Could you say a bit more about that - because that is very interesting to me when you say that, because you seem to feel it has made a change."

Him: "Well, for a start, I didn't have to stop so many times coming up a hill, and once I got to work and got going, I could work like the devil - I could do a normal day's work. But I couldn't do it now. They say you're not an invalid, and I admit you're not an invalid, but by the same running you've got your limitations, and they're limitations what you didn't have before. Because I said to the specialist this last time 'It's a pity I didn't go off work before it happened.' He said 'Well you say that, but no one can say when you're going to have a heart attack.' I said 'But nevertheless, the warning signs were there, but I couldn't see them - now the warning signs are there

all the time, because I can even go to bed some nights and lay there and I've got to get off the bed'. Still, it's not a heart attack pain - it's what I used to have before I had the heart attack angina they call it. So, when people say that they're cured from a heart attack, they probably are, but it's left it's mark - this is my experience. Sitting here like I am now, I'm as right as ninepence - but if I go down the club at lunchtime as I do, I've probably got to stop about four times on the way up. I explained this to the specialist - We went up the brother-in-law's one night....and I had a hell of a job to get home...."

(Normal - but reduced health status)

Her: "When we got there, they were out....we walked."

Him: "No, that was another night. We sat there yarning - it wasn't as if I'd been doing something. All I did was have a cup of tea....I bet it took us...."

Her: "He had a devil of a job to get home - we had to keep stopping."

Him: "Now that didn't use to happen before the heart attack. Whether the heart attack made the angina worse - well that's actually what it has done - it's made the angina worse."

Int: "Have the doctors talked to you any more about those pills to put under your tongue?"

Him: "I've still got them, but I don't take them very often, I don't want to get addicted to them, if you know what I mean. When you take one of them, they nearly knock your head off - they give you a terrific pain in the head. He told me that before I took any, and anybody else I ask about them, they say the same thing. They nearly blow your head off."

(Resistance to prolonged medication)

Her: "He told you to take one of those if you were going to do anything..."

Him: "....anything extra. Now probably, when I go to work, I shall probably take one in the morning before I go to help me to walk to work. I shall probably walk, as it's all on the level. Actually, I

shall have to see how I am - I haven't got a clue how I'm going to be at work, because I haven't done anything physical since....we was tiling the kitchen, but we've never finished, we haven't even painted. I haven't done anything. So I can't say just how I'm going to be when I get to work - it's more or less in the lap of the gods. But I ain't the same bloke as I was before I had the heart attack - that I do know. But sitting here I am. This is the peculiar part about it, and sometimes I think nothing of walking into town - in the mornings I can walk into town, but I can't walk up the hills back."

(Less confident about future than before)

Int: "Some people say to me that having the heart attack has made them more conscious of their age - that they hadn't realised that they were getting towards retirement age...."

Him: "Well, I think it hits everybody, 'cos it's something out of the blue for you - it's not like having appendicitis or having the flu, or having an accident at work, it's something out of the blue, and I think psychologically it makes you realise, but then it's not something that only hits older people, it hits people in their - I've got a pal and he's had two and he's not forty yet - the only thing it does make you do, it makes you take things a lot steadier - that's the main thing. People tell you you've got to take it easier - this (tapping his chest) tells you you've got to take it easy. You don't need people to say - it might affect some people different, I'm only speaking about my own case - I know I can't do what I did previous, so I don't try. As regards running up the stairs - you don't go running up the stairs - 'cos I could run up the stairs. One of my neighbours said to me, it'll stop you striding up the street like you used to do. Now I come up as slow as can be, as though I've got all the time in the world - I have all the time in the world, that's how I treat life now. I'm not afraid - I don't think about dropping dead or anything like that - that's the least of my worries 'cos I think if that happened, I shan't know anything about it, so I don't

bother about it. I go down the pub and have my couple of pints and a yarn with the lads, and a bet on the horses and - apart from ^{physic} physical exercise, I don't do a lot different to what I did before - but then I'm not doing ^{as} much physical exercise."

(Changes resulting from illness partly radical, partly minimal)

Int: You'll know more when you get to work.

Him: "I've an idea I'll be better when I'm at work. I don't know, I could be wrong. But I've an idea when I get to work and get moving a bit - it's not hard work, but you've got to keep moving - I can sit down if I want, but my arms have got to keep moving. And mixing with other people will take things off a little bit - you won't have quite so much time to think about things." On holiday caught himself out having difficulty walking back especially after a meal. "I told the doctor, and he said a certain amount of blood was being used digesting food, and that makes your heart work quicker, and the blood ain't coming through quick enough. So you just don't know what to do - there's nothing you can do, just take it easy.

(More uncertain)

If I was retiring age, I'd retire and get a little job. If I could work at my trade, I could do four hours a day." Friend has offered him a part-time job, but he can't do it. "The big thing for me when I get to work will be the monotony - I've never been used to doing the same thing all day long....I told that to the specialist." Doctor asked him what he thought about the school leaving age. He thought extra years at school were a waste for some children, though he would have liked it - "I don't know what I might have been - I might even have been a doctor! They've been very pleasant there." There was a muddle about his last appointment at the hospital - he had to go again which interrupted his time away. He was angry with the system. He had had to come back from Newcastle specially - is travelling around quite a lot without any bother.

Int: "Do you let him carry the suitcase now, Mrs. Jessop?"

Her: "No - I have to carry that." - but her sister brought the case back.

"No. He couldn't carry the case, I don't think."

(Discrepancy between her view and his expectation of it)

Him: "I don't think that would affect me. I don't think I could carry it upstairs. Going up the hills is when I have to stop. I've told them all this and he said 'That more or less tallies with our findings.' 'Cos everytime you go you have those things strapped onto you, and a blood test."

Int: "Has he talked to you about your weight?" (He was visibly fatter)

Him: "Oh ah! I had to start smoking - I put a stone and a half on, and he played hell. So I said 'You can please yourself, I packed up smoking, and I eat like a racehorse and I can't help it - I'm always hungry.' He said 'Well, perhaps if you had the odd cigarette it would take your hunger off a bit'. So that's what I done. I don't smoke the way I did before - about 7 or 8 a day, and it's taken a bit of my weight off. I could eat for a pastime - I've still got a good appetite."

(New health behaviour modified)

Her: "I have to put the food out of the way quick, or he'd eat all the time...."

(Covert management)

Him: He talked about how much he has eaten today, but...."having the odd cigarette....I don't think it makes that much difference." Will smoke less when he starts work. "It has made me a bit better tempered as well." He had found "it didn't need a lot to upset you."

Her: "He noticed things that he didn't notice before, and got a little bit hot up over it. Not so much with me, as with other people, such as his birds, if things didn't just go right, he'd get hot up over it." He got hot up over daughter-in-law doing things differently from her.

Him: They play games as a family, and usually he doesn't mind losing. Son has been to stay, and he could play with his grandson without getting pain.

Int: "Do you think that next summer, you will try to play bowls again? - of having stopped...."

Him: "If I can work, I'll be able to play bowls - this is how I look at it. Otherwise, it's all work and no play. Same as I said to the doctor about having half a pint - I said 'I'm not going to pack everything up, or else there'll only be work left' So that is the attitude I've taken to it."

(Revision of Threat - Loss - Value scales)

When we were on holiday, in the next chalet to us, there were two blokes there that had had heart attacks, and one a bit further along it's amazing the number of people - when it happened you don't think.

Her: "I suppose really, we've come that age where we notice these things. There does seem to be a lot happened...more than what there used to be."

Him: "This friend of mine, that was his second heart attack. One of the fellows that was in there while I was in - he had one of them pace-maker things - he just got beat in the final of the Coventry bowls championship. He was in hospital after me, and that was his second. So I guess he's adopted the attitude 'If it's going to come, it's going to come'. My attitude is, I don't want to do anything to help it - this is how I look at it. I'm too happy in my family life and everything to want that sort of thing. And so, for the sake of being a little bit careful, if I can live a couple of years longer, well I'm going to. This is the difference. When we go out on a Saturday night, he'll be sitting knocking back his pints, and I'll just have my couple of half pints - I'm quite content enjoying the company."

(Rejection of a 'cardiac wise' model)

Int: "You said it was just over five months - does it seem like that?"

Him: "It seems a long while now - yes. At first when I started being able to go out, it was like a holiday, it was a novelty, but now the novelty is beginning to....I don't say I find the time long, but..."

Her: "....you've done all the things you want to do."

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Her: "....you've done all the things you want to do."

Him:

"Yea. I went to Newcastle two or three times, and seen the kids, and we've been away on holiday, and....I think when the bad weather started to come on, I would find the time terribly long. So, I'm hoping it comes off for me when I start work - as I say, I'm not tied to do so much work or anything of the sort - I'm on a fixed wage.... I'm just hoping it works out all right. I'm more than expecting to be signed off next Friday week. It'll seem funny, I think, to be at work and got to stop there for the rest of the day, when you've been used to....

(Convalescence became institutionalised)

I said to the doctor 'I think I'm fit for work, but there's a lot of difference between being at home and being able to do what you like, but when you're at work, there's work to do, and there's a big difference'

(Less confidence)

But I've got no blood pressure - I've never had blood pressure - once my heart attack was over and they had sorted it out a bit. Every time I've been to the specialist, he's always said that. 'Cos I don't take no blood pressure tablets at all - some of them blokes are taking nine or ten." More about his tablets, and the new ones. Another appointment in two months time. "They seemed quite pleased with me - course, everyone tells me 'You've had a heart attack - but it's all right - but we can't do nothing about you angina'. Obviously it's to do with the veins that go to the heart - 'cos that's where you always get the pain. But I didn't realise that was the start of having a heart attack - I'd had them and never done anything about them - I probably stopped work for two or three minutes, and it went off. I used to have to stop going to work two or three times in the morning, but I used to think that was indigestion. Yet, a lot of people spart out, don't they. The lady in our office at work - when she has them, she collapses and goes right out."

Her:

"She might have got blood pressure with it."

Him: "Ah, yes, she has. Then you seem to tend to get a stroke when you've got blood pressure - a stroke seems to come into it more when you've got blood pressure than when you have an ordinary heart attack."

Her: "Now, my brother has got angina as well...."

Him: "And he's only 50 odd."

Her: "But then, his is different from your's because he can't sleep at night for his arms aching. Well, your arms don't ache."

Him: "He's a big chap with a big tummy, and he can't pack up smoking as he'd put on more weight. So, he's in a worse position, though he's still working - he's in the same trade as me, but he's in the aircraft - he had to come out of the car trades as it was too hard work. Of course, they won't start me back now on the aircraft at my age - we've just got to make the best of....a little job in the stores would have done me. You're not tied to any routine."

(Attempts to understand his condition by comparisons with other 'cardiac wise')

Her: "That may come - if there's an opening there, you are on the inside."

Him: "Inspection would have done me."

Her: "I'm not too keen on inspection, because you'd be to everybody's beck and call and that would worry you."

Him: "I've never been to anybody's beck and call all my life."

Her: "But then you see, that's when you get het up - so there's two ways of looking at things. You're not supposed to get het up, are you. Well you would do if anybody come to you and told you off about the inspections, and you'd tell them off, and where do you go from there! I reckon you'll be better off for the job you're going on."

Him: "You don't know the job I'm going on, dear, so you can't speak there I do."

Int: Said this was the last interview, but asked if I might ring him up after he started work to ask how it has gone.

Him: Son has got job in Nottingham. They are both very pleased to have them nearer. Prolonged discussion of their pleasure over these plans. What daughter-in-law said when she thought she had got to go into

hospital in Newcastle "there'll be no one to come and see me. I said 'You don't want to worry about anybody coming to see you in hospital, what you want to worry about is getting better. I didn't worry about anybody coming to see me while I was in hospital - it's nice when you start to get better, but when you start to get better, you ain't bothered so much. If you see too many people around the foot of the bed, you begin to think you are on your way out.'"

He had always had a lot of visitors - recapitulation of her visiting arrangements.

Int: I thanked them for all their help, and said I would telephone in a few weeks.

16.9.74. Telephone Call to Mr. Jessup.

He said he had started work the day he expected to - now three weeks ago - "I get a bit tired, but I suppose I'll get used to it....after five months, anything would be hard." The job was boxing - there was "nothing in it." Was having more pain, and was taking more pills because of it - quite regularly. By the end of the working day - "I've had enough - I have a sleep for an hour." Can take a day off when he wants to, and expects to lose more time in the winter. "I'm well in myself - but the wife worries if I comes home early - once you've had one, she always thinks there could be another."

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